

The NEWSSTAND



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As Doctors Get a Life, Strains Show

By Jacob Goldstein

U.S. medicine is in the middle of a cultural revolution, as young physicians intent on balancing work and family challenge the assumption that a doctor should be available to treat patients around the clock.

Walter Cheng, 32 years old, is in the profession's new guard. Upon graduating from the Johns Hopkins School of Medicine in 2004, he bristled at the notion espoused by some senior physicians that a doctor should put medicine above all else. "I thought, 'I don't really want to be that kind of doctor.'... My family is as important, if not more important, than my career."

That philosophy influenced Dr. Cheng's job search. Later this year, he plans to go to work as a hospitalist, an emerging breed of doctor that focuses on the general care of hospitalized patients. He was attracted to the job, at California Pacific Medical Center in San Francisco, by the intellectual challenge of treating acutely ill patients who wind up in the hospital. Another big draw: a predictable schedule. "You come in at a certain hour. When you leave, your pager turns off," he says.

In a 2006 survey conducted by physician-staffing firm Merritt, Hawkins & Associates, 63% of medical residents said the availability of free time was causing them "a significant level of concern" as they entered the profession, up from 15% in 2001.

While quality-of-life issues have been long-festering for physicians, today's medical field is more accommodating. Younger doctors' attitudes are giving rise to different types of practice options. These range from small, membership-based primary-care facilities to hospital-specific jobs that keep doctors on predictable schedules.

At the same time, the attempt by new doctors to lead a less-pressured work life is putting additional strain on America's health-care system. Many are eschewing fields such as internal medicine, pediatrics and family medicine, choosing instead specialties that offer both higher pay and more predictable work hours. In family medicine, for example, hundreds of medical residency positions go unfilled every year. But competition for slots in dermatology residencies is fierce.

Team-Based Approach

To adapt, American medicine is drifting away from the old standard -- in which a single doctor handled almost all of a patient's needs -- and toward a more team-based approach. This system includes not only multiple doctors but also nurse practitioners and physician assistants.

But rotating care among several medical professionals carries potential risks. Faced with an unfamiliar patient -- or incomplete knowledge of a person's condition -- a doctor may be ill-equipped to

make spur-of-the-moment, life-and-death decisions. Edward Salsberg, director of the Association of American Medical Colleges' Center for Workforce Studies, says the team-based model works only if doctors have "a good medical record, good handoffs, etc., so if it's three in the morning and you're ill, someone can get your information."

The arrangement can be unsettling for some patients, especially in fields often associated with a high level of physician contact, such as obstetrics. Yet some obstetricians are on call -- working at a moment's notice -- less frequently than in the past. In some hospitals, it is no longer uncommon for women to have babies delivered by a doctor who has never treated them before.

"It's an uncomfortable situation when you're giving birth," says Marissa Vergnetti, whose first child was delivered at Abington Memorial Hospital in suburban Philadelphia by a doctor she had never met. "I think if I had known the doctor, there could have been more of a dialogue about what was happening. Or maybe the doctor would have been more invested in me."

John J. Kelly, Abington's chief of staff, says the hospital strives to have all patients meet their doctors well before delivery. But he recognizes that that doesn't always happen.

Louis Weinstein, chairman of obstetrics and gynecology at Jefferson Medical College in Philadelphia, argues that the old OB-GYN model doesn't always benefit patients -- and that younger doctors' reluctance to be on call 24/7 may well be a good thing for both patient and practitioner.

"I can promise you that I will be available for your delivery, but I have no idea how many hours I will have been up and...how many c-sections I will have done" since awakening, Dr. Weinstein says, describing the traditional model. "Or I can assure you that one of my colleagues will be fresh, will be available and will be focusing just on you. Which would you prefer?"

Obstetricians who work fixed hours at the hospital are often referred to as OB hospitalists. The term "hospitalist" was coined in the 1990s to describe a new type of doctor who focuses on patients who are in the hospital.

Today, there are more than 20,000 hospitalists in the U.S., according to the Society of Hospital Medicine, and many work set hours for a fixed salary. Their pay is often 15% to 20% higher than what primary-care doctors make. The vast majority are generalists, but a growing number are trained in obstetrics and other fields.

Nashville, Tenn.-based hospital chain HCA has hired OB hospitalists to staff roughly 20% of its labor and delivery units. It plans to double that figure in the next five years, says Jonathan B. Perlin, the company's chief medical officer. Among other duties, OB hospitalists treat indigent patients who show up at the emergency room needing OB-GYN care. The hospital-based obstetricians also care for women during the early stages of labor or when a woman's doctor is unable or unwilling to go to the hospital.

'The Hero Model'

Having obstetricians who work set shifts improves patient care, says Dr. Perlin. "There is a very fortunate convergence of a new appreciation for patient safety, and leaving behind some of the hero model of the lone ranger who is there 24/7, 365," he says.

Although some might paint the "me" generation of doctors as less committed or focused, leaders in the profession don't necessarily support that view. "There has been a sea change in how young physicians today balance professional responsibilities and personal needs compared to their colleagues from a few decades ago," says American Medical Association President Ronald Davis. "Physicians who manage their own stress and feel happy with their own daily circumstances are probably better physicians," he says.

For some younger doctors, being on call -- even on prescribed nights -- is too much. Judy Marvin left a five-doctor practice in Spokane, Wash., three years ago, at age 39, because she found it difficult to both care for her patients and raise two small children.

On nights when she was on call, she says she was often awakened by phone requests from patients or nurses. "I'll never take another job where I have to take calls from patients" after hours, she says. Today, Dr. Marvin works in Salem, Ore., at an OB hospitalist program created in 2005.

Some senior physicians gripe about the younger generation's scheduling boundaries -- and complain that older doctors must often pick up the slack.

"It really gets on your nerves when you get these young guys coming in and interviewing and they say, 'I'm not doing this, I'm not doing that,'"

says Richard W. Schwartz, a 55-year-old professor of surgery at the University of Kentucky. "We have a bunch of guys in our 50s," he says, who handle most of the trauma and emergency calls.

'Controllable' Lifestyles

The shift was growing evident even five years ago. Between 1996 and 2003, the proportion of women graduating from U.S. medical schools who chose more "controllable" lifestyles -- specialties allowing them to dictate hours spent on the job -- doubled. Those opting for more flexible fields rose to 36% from 18%, according to a 2005 study published in the journal *Academic Medicine*. For men, it rose to 45% from 28%, the study showed.

At 1Life Healthcare, a primary-care company that employs roughly 10 physicians in four San Francisco locations, doctors see patients at the office only. And unlike the old doctor-patient contract, 1Life physicians don't follow patients to the hospital. Rather, they defer those cases entirely to the receiving facility.

The company was founded in 2003 by Tom Lee, a 40-year-old doctor who became disillusioned with primary care during his residency at Brigham and Women's Hospital in Boston in the late 1990s.

'Old-School Medicine'

"I envisioned myself doing old-school medicine. House calls, the way primary care was intended to be," Dr. Lee says. But he eventually found his vision at odds with the realities of modern health care, including administrative burdens, insurance paperwork and other bureaucratic headaches.

Physicians at 1Life earn a salary as well as productivity-based bonuses. They typically work four days a

week, for eight or nine hours a day. The company, which Dr. Lee founded after completing his MBA at Stanford University, pays doctors' malpractice insurance and manages billing. The doctors accept insurance, but patients also pay an annual membership fee of about \$100.

Other groups have created hybrid solutions that give doctors more predictable schedules. The obstetrician-gynecologists employed by Albert Einstein Healthcare Network in Philadelphia deliver babies only during three, 24-

hour shifts in the hospital each month. The rest of the time, they treat patients in an office-based practice.

The hospital initially adopted the model in 2004 to improve efficiency. As a side benefit, it has also served as a tool to attract and retain young physicians.

When Stephanie Almeida, who is 33, started a 24-hour shift one recent Tuesday morning, two women were in labor: one she'd seen once before and one she'd never met. In a short conversation,

the physician who was completing his 24-hour shift briefed her on the patients. A few hours later, Dr. Almeida had seen to the delivery of both women's babies.

Most expectant mothers don't mind the arrangement, Dr. Almeida says. That evening, another patient, Zaira Gonzalez, gave birth to twins. "I like it here," Ms. Gonzalez said of the hospital, where she had given birth before. Not knowing the physician "doesn't make a difference to me."

New York Times – April 28, 2008

Group Urges Ban on Medical Giveaways

By Gardiner Harris

Drug and medical device companies should be banned from offering free food, gifts, travel and ghost-writing services to doctors, staff members and students in all 129 of the nation's medical colleges, an influential college association has concluded.

The proposed ban is the result of a two-year effort by the group, the Association of American Medical Colleges, to create a model policy governing interactions between the schools and industry. While schools can ignore the association's advice, most follow its recommendations.

Rob Restuccia, executive director of the Prescription Project, a nonprofit group dedicated to eliminating conflicts of interest in medicine, said the report would transform medical education.

"Most medical schools do not have strong conflict-of-interest policies, and this report will change that," Mr. Restuccia said.

The rules would apply only to medical schools, but they could have enormous influence across medicine, said Dr. David Rothman,

president of the Institute on Medicine as a Profession at Columbia University.

"We're hoping the example set by academic medical colleges will be contagious," Dr. Rothman said.

Drug companies spend billions wooing doctors — more than they spend on research or consumer advertising. Medical schools, packed with prominent professors and impressionable trainees, are particularly attractive marketing targets.

So companies have for decades provided faculty and students free food and gifts, offered lucrative consulting arrangements to top-notch teachers and even ghost-wrote research papers for busy professors.

"Such forms of industry involvement tend to establish reciprocal relationships that can inject bias, distort decision-making and create the perception among colleagues, students, trainees and the public that practitioners are being 'bought' or 'bribed' by industry," the report said.

A group of influential doctors decried these practices in a 2006 article in *The Journal of the American Medical Association*, and said that medical schools should ban them. In the article's wake, the medical college association created a task force.

With Dr. Roy Vagelos, a former Merck chief executive, serving as the task force's chairman and the chief executives of Pfizer, Eli Lilly, Amgen and Medtronic on the roster, some who advocate for greater restrictions on industry influence in medicine predicted that the report would be weak.

They were wrong.

In addition to the gift, food and travel bans, the report recommended that medical schools should "strongly discourage participation by their faculty in industry-sponsored speakers' bureaus," in which doctors are paid to promote drug and device benefits.

It recommended that schools set up centralized systems for accepting free drug samples or "alternative ways to manage pharmaceutical

sample distribution that do not carry the risks to professionalism with which current practices are associated." It suggested that schools audit independently accredited medical education seminars given by faculty "for the presence of inappropriate influence." And it said the rules should apply to faculty even when off-duty or away from school.

Speakers' bureaus and drug samples are pillars of the industry's marketing operations, and many medical school professors have resisted efforts to restrict them. Only a handful of medical schools presently bar faculty members from serving on speakers' bureaus, so if this recommendation is widely adopted, it could transform the relationship between medical school faculty and industry, and it could change substantially the way medical education is routinely delivered.

Indeed, the chief executives of Pfizer and Eli Lilly dissented from the report's recommendation regarding speakers' bureaus.

"We continue to believe that these types of programs, which are subject to clear regulations regarding their content, can be worthwhile educational activities," wrote Jeffrey B. Kindler of Pfizer and Sidney Taurel of Lilly.

David Beier, an Amgen senior vice president, wrote a letter that endorsed the report's recommendations but disagreed with some of its text "because we have a different view about the accuracy concerning representations about the motives of the participants in industry-academic interactions."

Ken Johnson of the Pharmaceutical Research and Manufacturers of America, said his group would review the report.

"Providing physicians — and medical students — with timely, accurate information about the medicines they prescribe clearly benefits patients and advances healthcare throughout the United States," Mr. Johnson said.

Dr. Robert J. Alpern, dean of the Yale School of Medicine, said that the university presently had no limits on participation in company speakers' bureaus, but that because of the medical college association's report he was thinking of taking them on.

"I don't have a problem with doctors making \$3,000 or \$5,000 a year on the side," he said, "but it's a totally different thing when it's \$80,000." Even more distasteful, Dr. Alpern said, is that the slides used in many of these presentations are created by drug makers, not the speakers.

"That's like ghost-talking," Dr. Alpern said.

Dr. Arthur S. Levine, dean of the University of Pittsburgh School of Medicine, said that when he graduated from medical school in 1964, Eli Lilly gave him his first doctor's bag, and Roche gave him an Omega watch for being valedictorian. He still has the watch.

But this year's graduating class of doctors at Pittsburgh will not be allowed to accept any of these gifts, and the daily pizza lunches brought by drug companies are gone, he said.

Julie Gottlieb, assistant dean of policy coordination for Johns Hopkins University School of Medicine, said Hopkins had adopted some of the association's recommendations and was considering others.

"This report is bound to influence our deliberations," she said.

Dr. Vagelos, formerly of Merck, said that the report's recommendations were certain to face resistance among faculty who liked the present system.

"The outcome of this for the industry is that those companies that are strong in science will always be welcome at medical colleges and others won't," Dr. Vagelos said.

Des Moines Register — May 1, 2008

Iowa Hispanic population still climbing, data show

By Jane Norman

Washington, D.C. — Iowa's Hispanic population continues to steadily grow, with the state gaining more than 36,000 Hispanic residents since 2000, according to new census estimates to be released today.

Nearly 120,000 people who report they are Hispanic lived in Iowa as

of July 1, 2007, a 44 percent increase since the 2000 census.

Just between 2006 and 2007, there was a 4.8 percent rise in the Hispanic population in Iowa, outstripping a national increase of 3.3 percent that made Hispanics the nation's fastest-growing minority

group. The U.S. Hispanic population was more than 45 million.

The Iowa increase came even after toughened federal enforcement at the U.S.-Mexico border, as well as the December 2006 raids at the Swift & Co. plant in Marshalltown

that resulted in 90 arrests on immigration charges.

Mark Grey, director of the Iowa Center for Immigrant Leadership and Integration, said that census numbers traditionally understate minority and transient populations. He said he would guess there are closer to 140,000 Iowans of Hispanic origin. Census estimates do not specify people's legal status.

"The economic forces at work are going to bring people into the state — they're not going to push them out," said Grey, a University of Northern Iowa professor of anthropology. More immigrants from Central America are coming to Iowa, and Guatemalans appear to be the largest group of people of Hispanic origin in Iowa now, Grey said.

The increases in Hispanic population continue to drive the state's overall increase in population.

Between 2000 and 2007, Iowa grew overall by 59,800 men, women and children. Of that number, an estimated 36,491 were of Hispanic origin, or 61 percent.

Still, Hispanics make up just 4 percent of the population in a state of 2.98 million that remains largely white and native-born.

Nathan Blake, 28, of Des Moines is a member of the Iowa Commission of Latino Affairs, and is half

Hispanic. He said it's his perception that Iowa's growth remains steady but not as explosive as in states closer to the Mexico border, and likely more visible in Iowa's urban areas.

"Maybe you notice a few more Mexican restaurants. Maybe you notice the people in your kids' classes have a little more diversity," he said.

Concerns recently brought to the commission's attention include lingering anger and distrust from the Swift raids, problems with access to affordable health care, and the treatment of Hispanic children in schools, Blake said.

Sal Alaniz of Mount Pleasant, another member of the commission, said the word most Hispanics use to describe Iowa translates into "tranquil," and that's why the state is seen as desirable.

"They tend to come here and live a tranquil and participatory kind of life," he said, with entrepreneurs saving and building new businesses like generations of earlier immigrants.

A 2006 report by the Century Foundation written by UNI's Grey labeled Iowa a "new destination state" for thousands of immigrants, particularly Latinos.

The impact is felt in school districts grappling with dramatic growth in English Language Learner students,

hospitals struggling to meet the needs of immigrants who lack health insurance, worries among law officials that illegal immigrants will drive without licenses or insurance, and local resistance to building new housing to accommodate immigrants, Grey reported.

An age gap also exists between the mostly white residents of Iowa and members of minority groups.

Iowa's median age was estimated at 38 — the 12th-highest in the nation — up from 36.7 in 2000. But the median age for white Iowans is 38.9, while the median age for black Iowans is 25.2 and the median age for Hispanic Iowans is 24.6.

The number of very elderly Iowans continues to climb as well, rising from 65,000 Iowans age 85 or older in 2000 to more than 77,000 now.

There were about 438,000 Iowans age 65 or older in 2007, compared with 436,000 in 2000.

A bigger population bump was seen in baby-boomer Iowans age 45 to 64, who increased from about 654,000 in 2000 to nearly 777,000 in 2007.

At the same time, the number of children and teens in Iowa continued to contract, with those under 18 declining from about 733,000 in 2000 to 711,000 in 2007.

Kansas City Star – April 28, 2008

Missouri Senate passes revamped health-care bill

By Kit Wagar

After weeks of hand-wringing over health care, the Missouri Senate approved legislation Monday that includes a new version of Gov. Matt Blunt's plan to help the uninsured.

The 30-4 vote and brief debate gave little indication of the controversy that will follow the bill as it moves to the House.

Democrats' main criticism is that it fails to provide coverage for all of

the 90,604 low-income residents kicked off Missouri's Medicaid program three years ago. Sen. Joan Bray, a St. Louis County Democrat, reiterated those concerns Monday.

“This does nothing for the poor people who lost access to health care in 2005,” Bray said. “Until you help poor people who have no access to health care, you’re really not doing anything. We shouldn’t be spending our time and resources not getting results for the people who matter.”

Many Republicans are upset with a plan that would potentially subsidize medical insurance for people well into the middle class. Rep. Rob Schaaf, a St. Joseph Republican, last week circulated a memo deriding the plan as “a new \$400 million-plus health welfare program to cover able-bodied adults.”

Schaaf, a physician, also took on the Missouri Hospital Association by demanding that any new health plan end the requirement to obtain state permission before opening a hospital.

The 88-page bill includes a wide range of programs intended to make consumers more aware of the true cost of health care and to help them make informed choices. The bill sets up an organization to publish reports on medical mistakes such as

surgery on the wrong body part or serious medication errors.

It sets up a fund to discourage smoking, provides a tax deduction for the cost of certain high-deductible health insurance policies and encourages health insurers to publicly compare the quality and cost efficiency of health-care providers in their networks.

But the centerpiece of the bill is a retooled version of the governor’s Insure Missouri plan. If funded by the legislature, the plan would provide medical coverage for people aged 19-64 with income of up to 225 percent of the poverty level — or \$46,467 a year for a family of four.

To qualify, participants could not have access to affordable employer-provided health insurance and must have been without health insurance for at least six months.

The deductible would be paid on a sliding scale based on income, with a maximum of \$1,000 a year. People living below the poverty level would not have to pay anything. People with incomes up to 125 percent of the poverty level

would pay just 2 percent of their income — or about \$43 a month for a family of four with income up to \$2,151 a month.

At the top of the income-eligibility scale, participants would pay up to 5 percent of their household income, up to \$1,000 a year. Employers could pay up to half the deductible.

The plan would cover an estimated 54,500 people living below the poverty level, officials estimate. When fully phased in, it could provide insurance for slightly more than 200,000 people in Missouri.

Because of criticism of the high administrative costs included in previous versions of the plan, the Senate plan limits total administrative costs to a maximum of 7 percent of all funds appropriated for the program.

The program relies primarily on federal funds and special hospital taxes that are used to leverage additional federal matching money. But the program is projected to cost at least \$40 million in state general funds next year.

Wall Street Journal – May 1, 2008

HSA Users Find Hassles Amid Savings

By M.P. McQueen

The public debate over consumer-driven health care is heating up.

High-deductible insurance plans paired with health-savings accounts -- so-called HSAs -- are a centerpiece of Republican presidential candidate John McCain's platform, even as the Democrats aim for universal health care. But new scrutiny of the plans, and the experience of people who have begun using them, are highlighting a number of challenges HSAs face in truly winning over consumers.

A report released Wednesday by the Government Accountability Office, the investigative arm of Congress, found that HSA users were much wealthier than people covered by other types of plans, based on 2005 tax data. "HSAs clearly are attractive to higher-income people who are looking for tax shelters. But they aren't the answer for providing adequate health-insurance coverage for the average American," says Rep. Henry Waxman (D., Calif.), one of the congressmen who requested the report.

Karen Ignagni, CEO of America's Health Insurance Plans, a trade group of insurers, says the GAO analysis was based on information from 2005, and that "newer data indicate that individuals are not storing assets in these account but using them for health-care services."

Certainly, many employers and workers are satisfied with the new plans, citing cost savings. Premiums on the high-deductible policies can be much lower than for traditional

plans. And a recent study by consulting firm Watson Wyatt found that average health-insurance costs rose 3.6% in the past two years for employers who offered high-deductible plans, compared with a rise of 7% for employers without such plans.

Some analysts say much of those employer savings come because many HSA participants tend to forgo care. "There is a lot of evidence that suggests that when patients pay a higher percentage of the cost of their care they get less of it," says Michael Thompson, a principal at PricewaterhouseCoopers, which advises employers on health plans.

In health-savings accounts, consumers -- often aided by their employers -- save money in tax-advantaged accounts that can roll over from year to year, although many people with high-deductible plans forgo opening an HSA. The funds can be withdrawn tax-free if used for qualified medical expenses. The accompanying high-deductible insurance plans carry premiums that can be as much as 50% lower than those of a traditional comprehensive plan. The plans have deductibles of at least \$1,100 for an individual and \$2,200 for a family in 2008. In essence, it's almost like being self-insured for initial expenses. And plans associated with HSAs do not pay for prescription drugs.

That's very different from traditional group health insurance, which typically begins right away paying doctor and prescription bills. Consumers often make a small co-payment, and possibly pay a percentage of the bills up to an annual limit. Some economists have long complained that that system encourages consumers to be wasteful about spending since they don't pay directly for much of the costs.

Of course, traditional health plans can also present problems, including excessive paperwork, incomprehensible explanation-of-benefit statements and rising costs. But some individuals are surprised to find little improvement after switching to high-deductible plans with HSAs.

Robert Daubin, a self-employed Web developer in San Francisco, says he pays \$215 monthly for individual insurance with a \$4,000 deductible under his Simple Choice plan from Health Net Inc. Last year, he suffered a pinched nerve and paid \$1,200 out of pocket for treatment, because he hadn't yet funded an HSA. "It was higher than I expected." Mr. Daubin, 46, says he might choose an HMO plan next year.

Among other problems some HSA users cite: The savings accounts can only be owned individually, which can prevent a spouse from raising questions about reimbursements or shifting investments. And reimbursements from HSAs for out-of-pocket expenses can take time, creating cash-flow problems for some individuals.

Self-employed attorney Jonathan Stein, 34, of Elk Grove, Calif., got an HSA in 2005. Because he is responsible for paying the entire bill, he didn't go to the doctor for a recent bout of flu and doesn't get annual physicals despite a family history of heart disease and cancer. "My doctor and I fight about that when I do see her because she wants me to come in every year," Mr. Stein says. "If it was covered by insurance I'd probably go."

To encourage preventive care, some high-deductible plans have begun covering the full cost of services such as annual checkups.

Participants in HSAs can invest the money in their accounts, which are

held at brokerages and banks, but fees can be high.

Bill Greene, 61, a retired surgeon in Myrtle Beach, S.C., looked into opening an HSA at a full-service brokerage, but he says the fees were too high, including \$50 transaction fees per trade, and fund choices were limited. Dr. Greene searched online and decided to open an account at Sovereign Bancorp Inc. because it charged lower fees and offered some no-load mutual funds.

A Merrill Lynch spokesman says the brokerage currently is waiving its maintenance fee of \$50 to \$100 for new HSAs. As for transaction fees, he says, "as a full-service provider, we feel that fees are commensurate with services."

Still, HSA plans have some strong backers. Michael Vittoria, vice president of human resources for the U.S. unit of Sperian Protection SA of France, which makes personal protective gear, says a growing share of its nearly 1,200 workers in Rhode Island have been signing up since the company's HSA plan was introduced early last year. This year, 30% of employees opted for the HSA plan, up from 23%, and few employees have switched back to a traditional plan, he says. He estimates the plan has so far saved the company \$8 million in premiums.

Meg Manley, 63, a human-resources database administrator at Sperian, switched to the HSA plan last year. Shortly afterward, her husband, who is 65 and retired, was diagnosed and treated for skin cancer, incurring bills totaling \$5,000 for treatment. Ms. Manley had a \$2,250 deductible under the plan. But after Sperian's \$500 contribution to employees' HSAs, her out-of-pocket expenses totaled \$1,750, she says.

"I love it because my premiums are [less than] what they would be for

the regular PPO plan and the money that is taken out of my pay each week can earn money," Ms. Manley says. She now pays a \$52 biweekly premium, down from \$84 under her old plan.

Watson Wyatt expects 54% of big companies next year to offer high-deductible health plans, many of which are HSA eligible, up from 39% in 2007. Since the plans were

introduced in 2004, more than six million Americans have enrolled in HSA-eligible plans, although that represents a small percentage of the more than 200 million people with private health coverage.

Wall Street Journal – May 1, 2008

Vital Signs in Health-Care Debate

By David Wessel

Republican John McCain and Democrats Hillary Clinton and Barack Obama are laboring with understandable vigor to contrast Republican solutions to the ailments of the American health system with Democratic ones. The differences are sharp.

But in some key areas, the two sides are inching away from their traditional corners toward the middle of the ring, a change that's a necessary step toward getting something done.

Campaign proposals are watercolors, not photographs. Details are often indistinct. Attempts (including mine) to price candidates' proposals and identify how they'd pay for them inevitably founder on unverifiable assertions, unspecified technicalities and arithmetically accurate, but politically improbable, cost-cutting vows.

In the watercolor version, Sen. McCain would make health care more like the market for everything else, offering vouchers -- that is, tax credits -- so Americans can shop for health insurance like they shop for cars. Covering everyone isn't a priority, nor is keeping employers providing insurance; less regulation and less government are priorities.

The Clinton-Obama approach -- differences between the two candidates are smaller than they suggest -- prizes coverage for nearly everyone. Both would push individuals to buy insurance, press

employers to chip in, impose new rules and expand government insurance to fill gaps.

And all three candidates promise pain-free ways to restrain costs. Most aren't clear money savers, though. If you don't hear providers yelping about it, it isn't going to save money, counsels John Sheils of health consulting firm Lewin Group.

But at a Washington forum this week, Len Nichols, a veteran of the failed Clinton health initiative of the 1990s now at the New America Foundation, and Joseph Antos, a Republican economist at the American Enterprise Institute, each ticked off some virtues of the other side's plan.

Without the class-warfare rhetoric used by Democrats, for instance, Sen. McCain acknowledges inequities in today's \$220 billion-a-year in tax breaks for health insurance. The lucky two-thirds of Americans get health insurance through their employers, but they don't pay any taxes on the benefit. The break is worth much more to high-bracket taxpayers than low-bracket taxpayers, and worth nothing to those Americans who don't have health insurance.

Sen. McCain would replace that tax break with a \$5,000 tax credit for every family, no matter what their tax bracket or where they get insurance. Take from the rich, give to the bottom half, a Democratic applause line.

This week, Sen. McCain conceded that not everyone who wants to buy insurance under his plan would find it. So he suggested a vaguely articulated network of nonprofit, government-sponsored outfits that would contract with private insurers, set "reasonable limits" on premiums and offer subsidies to low-income families. That's far from Hillary Clinton's 1993 "health alliances," and definitely not universal coverage, but an admission that the market can't do the job alone.

Democrats, meanwhile, have moved away from the 1993 Clinton approach. "They have elements of consumerism that might surprise people," Mr. Antos says. They have moved toward Republicans in proposing to subsidize individuals so they can shop for insurance; they emphasize more than ever the virtues of people choosing from among competing health plans.

And, though he accuses Democrats of low-balling the price tag, Mr. Antos praises them for acknowledging that expanding access to health care will cost money. Indeed, Sen. Clinton's first campaign speech on health, in May 2007, focused not on universal coverage, but on costs. "I think we finally have a recognition that everyone sees there is an economic imperative to rein in costs," she said.

Paying for those costs? Well, Mr. Antos (and, privately, some Democratic analysts) translates

Democratic candidates' rhetoric this way: "We're going to get rid of the Bush tax cuts and do that as many times as necessary to pay for all this stuff."

Not to worry. There's still plenty to argue about. By eschewing the hugely popular goal of nearly universal coverage -- which means making sure the poor can afford insurance they want and the young and healthy are forced to buy it even though they think themselves immortal -- Sen. McCain fuels the debate over "whether" to expand coverage, instead of how to do it.

Mr. Nichols says that Sen. McCain's plan to allow people in one state to

buy individual insurance in another -- essentially deregulating this part of the insurance market -- amounts to "ideology trumping policy." Rational insurers will attract the healthy with low premiums and boost premiums for those with pre-existing conditions. "Fifty to 75 million Americans will discover what 'actuarially fair' really means," he says. (Sharply higher premiums.) The result, he predicts, will be a rush to Medicare-for-all that Republicans will hate.

Mr. Antos counters by focusing on the Clinton-Obama proposals for forcing private insurers to compete against expanded government health-insurance plans. The

government's muscle is so great it will dictate prices to hospitals and doctors below those offered to private insurers, he warns. "Clinton and Obama tie the hands of private insurers, and then say 'let's have a race,'" he complains. The result, he predicts, will be a rush to a government-run health-care plan that he suspects many Democrats long for.

The moment of compromise isn't at hand; voters are offered a choice between two fundamentally different approaches. But behind the rhetoric, there's movement.

Washington Post – May 2, 2008

Report Questions Quality of Medical Care for Workers in War Zones

By Stephen Barr

An increasing number of federal employees are serving in Iraq and Afghanistan, but it is not clear that the government's policies go far enough to ensure they receive the best medical care or the most appropriate benefits, according to a congressional report released yesterday.

The report was issued by the House Armed Services Committee oversight and investigations subcommittee, which looked into the incentives and medical coverage being provided to civil service employees.

Rep. Vic Snyder (D-Ark.), the subcommittee chairman, and Rep. Todd Akin (Mo.), its ranking Republican, told reporters that the review turned up a number of concerns.

The Defense Department, for example, has issued a memo that provides medical care for injured

Defense civil service employees at the same level and scope of that provided to military personnel. But that directive may not be sufficient or properly implemented, the report said.

"The Walter Reed experience demonstrated you need to have a very reliable system of a medical case coordinator for uniformed people who are in a very disciplined environment," Snyder said. "This may not be the situation for our civilian folks who are injured or hurt."

Federal employees also may not have access to the latest medical advances for treating combat wounds, he said.

"If you are a Department of Agriculture person and you have some kind of severe wound, when you come back to the states, the expectation is that you are going to be taken care of through your

normal health care system," Snyder said. "Well, the best experts in the world may be in the military treatment facilities to which you are not going to have access."

About 10,000 federal employees have volunteered for duty in Iraq and Afghanistan, the subcommittee estimated. The Defense Department has about 3,000 civilian employees in the two countries now.

The numbers are likely to increase if the departments of State and Defense continue with stabilization and reconstruction plans. President Bush's fiscal 2009 budget also would pull together more than 2,000 federal employees from 15 agencies for a "response corps" and would create a civilian reserve corps of about 2,000 drawn from state and local governments and nonprofit organizations.

Snyder said the report grew out of an investigation of Provincial

Reconstruction Teams, the joint military-civilian teams that help rebuild communities in Iraq and Afghanistan, often in dangerous conditions.

Congress expects that all government agencies are going to work closer together and that successful cooperation hinges on how people are treated, Snyder said. "And if we are not treating them in an adequate and equitable manner, then that is part of the flaw that we have in our interagency process," he said.

In examining the reconstruction teams, Akin said the subcommittee learned that "we really don't have a system to create any incentives to get these people to volunteer."

The subcommittee found that the federal workers' compensation

program, set up to deal with the typical injuries that happen in a workplace, is the primary source of medical coverage for wounded federal employees returning from the combat zones.

In the workers' comp program, the burden of proof for validating a combat-zone injury falls on the employee and can require substantial time and paperwork. The report recommends that the program form a special office that is adequately staffed and able to readily answer questions from wounded employees.

Snyder said it took about a month for the workers' comp program to respond to the subcommittee's questions about what types of war-zone injuries qualify for coverage. The program, for example, determined that an off-duty

employee playing basketball who was injured by mortar fire would be covered by the program.

Snyder and Akin said that many of the issues raised by the subcommittee review are outside the jurisdiction of the Armed Services Committee, but that the panel intends to continue studying civil service benefits, incentives and medical care as they relate to combat zones. The Congressional Research Service and the Government Accountability Office are collecting data, and the Defense Department has been asked to provide a report on civilian benefits.

"These things have not been carefully analyzed or defined," Akin said.