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OBAMA STRATEGY ON HEALTH LEGISLATION APPEARS TO PAY OFF

New York Times -

Nov. 2: Washington - After months of plodding work by five Congressional committees and weeks of back-room bargaining by Democratic leaders, President Obama's arms-

length strategy on health care appears to be paying dividends, with the House and the Senate poised to take up legislation to insure nearly all Americans.

Debate in the House is expected to begin this week, and the Senate will soon take up its version. Democratic leaders and senior White House officials are sounding increasingly confident that Mr. Obama will sign legislation overhauling the nation's health care system a goal that has eluded American presidents for decades.

The Senate Finance Committee chairman, Max Baucus of Montana, described "a sense of inevitability, the sense that, yes, we're going to pass health reform." In interviews, senior advisers to the president said the progress on Capitol Hill vindicated Mr. Obama's strategy of leaving the details up to lawmakers, though they are wary of sounding overconfident.

"You don't see any shimmying in the end zone," said Rahm Emanuel, the White House chief of staff. "No spiking the ball on the 20-yard line here." The bills have advanced further than many lawmakers expected. Five separate measures are now pared down to two. But the legislative progress has come at a price. In the absence of specific guidance from the White House, it has moved ahead in fits and starts. From here on, the challenges will only grow more difficult.

In the House, where leaders have vowed to pass a bill by Nov. 11, a fight over abortion coverage could still imperil the legislation, and Mr. Obama could lose some votes from liberals upset that the bill includes a weakened "public option," a government insurance plan to compete with the private sector. Mr. Obama, trying to keep progressives in line, met with them Thursday night in the White House Roosevelt Room.

"He is making the case to them that this isn't the exact bill you'd write, however, let's take a step back and look at what we're about to do here, and what a historic moment this will be," said a senior administration official, speaking on condition of anonymity to discuss a private meeting.

In the Senate, where Democrats will need support from every member of their caucus to reach a critical 60-vote threshold to avoid a potential filibuster, Mr. Obama's hands-off strategy carries particular risks. Without clear direction from the president on the public option, the Democratic leader, Senator Harry Reid of Nevada, moved ahead last week on his own, unveiling a bill that includes a government-run plan, but allows states to opt out.

Within hours, the proposal was being questioned by centrist Democrats whose concerns Mr. Obama must now address. As Senator Benjamin L. Cardin, Democrat of Maryland, said, "When you are seeking 60 votes, every person is a kingmaker."

Last week's back-and-forth in the Senate was emblematic of a process that has at times seemed on the brink of anarchy. Lawmakers have missed many deadlines, including the one Mr. Obama set for all five Congressional committees to wrap up work by August. (Only four did.) Even close allies of the White House sometimes questioned its approach.

"It felt like it was getting out of control at the end of July and in the beginning of August," said John D. Podesta, a former chief of staff to President Bill Clinton who informally advises the Obama White House. "People were getting nervous that it was going every which way." Mr. Podesta said the president risked "giving too much rope to a Congress that is liked a lot less than he is."

Mr. Obama said early on that he would not repeat the mistakes of Mr. Clinton, who wrote his own detailed plan, only to see it fall flat on Capitol Hill.

Instead, the president set out broad principles an approach that the House speaker, Nancy Pelosi of California, acknowledged at a rally last week, when she thanked Mr. Obama for “the intellectual contributions” he had made to the legislation.

The president’s distance caught Congressional Democrats by surprise. It took them months to realize that Mr. Obama would not weigh in on some issues, like the precise shape of a government insurance plan. One House Democrat called it a “a laissez-faire strategy.”

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HOUSE HEALTH BILL TOTALS $1.2 TRILLION

Associated Press -

Nov. 3: Washington - The health care bill headed for a vote in the House this week costs $1.2 trillion or more over a decade, according to numerous Democratic officials and figures contained in an analysis by congressional budget experts, far higher than the $900 billion cited by President Barack Obama as a price tag for his reform plan.

While the Congressional Budget Office has put the cost of expanding coverage in the legislation at roughly $1 trillion, Democrats added billions more on higher spending for public health, a reinsurance program to hold down retiree health costs, payments for preventive services and more.

Many of the additions are designed to improve benefits or ease access to coverage in government programs. The officials who provided overall cost estimates did so on condition of anonymity, saying they were not authorized to discuss them.

House Speaker Nancy Pelosi has referred repeatedly to the bill's net cost of $894 billion over a decade for coverage. Asked about the higher estimate, Pelosi spokesman Brendan Daly said the measure not only insures 36 million more Americans, it provides critical health insurance reform in a way that is fiscally sound.

"It will not add one dime to the deficit. In fact, the CBO said last week that it will reduce the deficit both in the first 10 years and in the second 10 years," Daly said.

Democrats have been intent on passing legislation this year to implement Obama's call for expanded coverage for millions, curbs on industry abuses and provisions to slow the rate of growth of health care costs nationally.

"Now, add it all up, and the plan I'm proposing will cost around $900 billion over 10 years," the president said in a nationally televised speech in early September.

Whatever the final cost of legislation, the calendar is working increasingly against the White House and Democrats. While a House vote is possible late this week, Senate Majority Leader Harry Reid, D-Nev., may not be able to begin debate on the issue until the week before Thanksgiving. Additionally, the Republican leader, Sen. Mitch McConnell of Kentucky, has hinted at efforts to extend the debate for weeks if not months, a timetable that could extend into 2010.

One casualty of the time crunch and threatened Republican delaying tactics may be formal House-Senate negotiations on a final compromise. An alternative is a less formal hurry-up final negotiation involving the White House and senior Democrats.

Pelosi and her lieutenants worked on last-minute changes in the measure to ease concerns among opponents of abortion and a contentious provision relating to illegal immigrants. Conservative Democrats have expressed concern about the cost of the bill, and an evening closed-door meeting gave the leadership its first chance to hear their response.

The bill includes an option for a government-run health plan. The leadership can afford more than two dozen defections and still be assured of the votes to prevail on the bill, one of the most sweeping measures in recent years.

Republicans put the cost of the bill at nearly $1.3 trillion. "Our goal is to make it as difficult as possible for" Democrats to pass it, House Republican leader John Boehner, R-Ohio, said at a news conference. "We believe it is the wrong prescription."

One day after announcing Republicans would have an alternative measure, Boehner offered few details. He said it would omit one of the central provisions in Democratic bills — a ban on the insurance industry's practice of denying coverage on the basis of pre-existing medical conditions. Instead, he said the Republicans would encourage creation of insurance pools for high-risk individuals and take other steps to ease their access to coverage.

Boehner also said Republicans would propose limits on medical malpractice lawsuits in what he said was an attempt to reduce the cost of coverage.

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MANDATES AND AFFORDABILITY ON HEALTHCARE REFORM

New York Times -

Nov. 2: If Congress approves health care reform, virtually all Americans will be required to buy health insurance or pay a penalty. That raises a fundamental question: Will the policies be affordable?

People everywhere are complaining that relentlessly rising costs are making health insurance unaffordable. The situation is especially dire for millions of Americans who are uninsured, self-employed or whose employers do not offer subsidized group coverage.

A survey by the Commonwealth Fund found that 73 percent of the adults who tried to buy insurance on the open market over a three-year period never bought a plan because they could not afford it, could not find a plan that met their needs, or were turned down.

Pending legislation would help some of them by preventing rejections or high charges based on health status and by setting minimum benefit requirements.

But many people who might still find the premiums too high will face an agonizing choice: buy insurance coverage or pay a penalty of hundreds or even thousands of dollars per family if they still decide to forgo insurance.

Successful reform will provide financial support for those who need it and is the only way to finally guarantee coverage for tens of millions of uninsured Americans.

Here is a look at some of the issues behind the affordability debate:

WHY IS A MANDATE NECESSARY? It is important that everyone be required to buy insurance, either from their employers or on new insurance exchanges.

Reliable studies show that people who lack insurance seldom get regular medical care and therefore suffer more severe illness and death than those who are insured. When they do get sick, they often turn to expensive emergency rooms for free care driving up costs for everyone else.

Finally, the health care reforms, which require insurers to accept all applicants, will not work well unless nearly everyone carries health insurance. Unless the pool includes a large number of healthy people, the costs for everyone on the exchange will be too high.

WILL PREMIUMS GO UP OR DOWN? Those forced to buy their own insurance could choose from an array of private plans and possibly a public plan that will be offered on the exchanges. There is sharp debate over whether these plans would be less or more expensive than plans that would be available on the open market.

Insurance industry studies contend that premiums would go up because various fees imposed on health insurers and health care providers to pay for covering the uninsured would inevitably get passed on to consumers.

We believe premiums would come down for several reasons. Companies would no longer need to spend as much money on administrative costs, to screen out people with pre-existing conditions (prohibited by all reform bills). If they wanted to participate on the exchanges (and have access to millions of new customers), the companies would also be forced to compete with other private plans, and possibly a public option, encouraging them to lower premiums and accept lower profits.

A hint of what might happen can be seen in an analysis by the Congressional Budget Office. Under a version of the Senate Finance Committee bill, the average single person would pay a $5,000 premium for a 'silver plan' sold on the exchanges in 2016 but would pay $6,000 for a plan with less generous coverage if the reform failed.

WILL THERE BE HELP? Right now, only the poorest Americans get help, through the state-federal Medicaid program. The bills in both houses would expand eligibility for Medicaid to cover millions more people, and lower the contributions of the poorest Americans.

For those buying policies on the exchanges, perhaps 30 million people in all, the bills would provide tax-credit subsidies to help low- and middle-income people pay the premiums. People would have to pay specified percentages of their income toward the premium, ranging in the House bill from 1.5 percent for those barely above Medicaid level to 12 percent for those earning four times the poverty level, or $88,000 for a family of four.

That sounds like a substantial hit at the upper end $10,560 for a family of four before subsidies kick in. But it is comparable to what many workers are currently willing to pay for their group policies.

And just in case the premiums might still look unaffordable to large numbers of people, the Senate Finance Committee's version has proposed an escape hatch. No one would be required to spend more than 8 percent of their income on health insurance. They would not be insured, but they would not be fined.

WHAT'S AFFORDABLE? No one has a clear answer, and various experts use different

approaches to calculating affordability. Some estimate what people would have to pay for such other necessities as housing, food, day care, transportation and taxes, and then see how much is left over that could pay for health insurance. Others look at what people at various income levels are paying for health insurance today, without a requirement.

By either yardstick, Jonathan Gruber, a prominent health economist at the Massachusetts Institute of Technology, believes that all of the pending bills in Congress would make health insurance affordable to the vast majority of Americans and that none of the bills would require anyone to buy insurance they could not afford.

His only concern is that the Senate Finance Committee's bill might not provide enough protection against high payments required to meet deductibles or co-payments and other out-of-pocket charges.

The Commonwealth Fund, a staunch advocate of health care reform, believes that the House bill meets its affordability standards (5 to 10 percent of income) for premiums required of families earning up to about $75,000 a year, while the Senate Finance panel's bill falls short at every step of the way.

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AFTER ALL THE FUSS, PUBLIC HEALTH PLAN COVERS FEW

Associated Press -

Nov. 1: Washington - What's all the fuss about? After all the noise over Democrats' push for a government insurance plan to compete with private carriers, coverage numbers are finally in: Two percent.

That's the estimated share of Americans younger than 65 who'd sign up for the public option plan under the health care bill that Speaker Nancy Pelosi, D-Calif., is steering toward House approval.

The underwhelming statistic is raising questions about whether the government plan will be the iron-fisted competitor that private insurers warn will shut them down or a niche operator that becomes a haven for patients with health insurance horror stories.

Some experts are wondering if lawmakers have wasted too much time arguing about the public plan, giving short shrift to basics such as ensuring that new coverage will be affordable.

"The public option is a significant issue, but its place in the debate is completely out of proportion to its actual importance to consumers," said Drew Altman, president of the nonpartisan Kaiser Family Foundation. "It has sucked all the oxygen out of the room and diverted attention from bread-and-butter consumer issues, such as affordable coverage and comprehensive benefits."

The Democratic health care bills would extend coverage to the uninsured by providing government help with premiums and prohibiting insurers from excluding people in poor health or charging them more. But to keep from piling more on the federal deficit, most of the uninsured will have to wait until 2013 for help. Even then, many will have to pay a significant share of their own health care costs.

The latest look at the public option comes from the Congressional Budget Office, the

nonpartisan economic analysts for lawmakers. It found that the scaled back government plan in the House bill wouldn't overtake private health insurance. To the contrary, it might help the insurers a little.

The budget office estimated that about 6 million people would sign up for the public option in 2019, when the House bill is fully phased in. That represents about 2 percent of a total of 282 million Americans under age 65. (Older people are covered through Medicare.)

The overwhelming majority of the population would remain in private health insurance plans sponsored by employers. Others, mainly low-income people, would be covered through an expanded Medicaid program.

To be fair, most people would not have access to the new public plan. Under the House bill, it would be offered through new insurance exchanges open only to those who buy coverage on their own or work for small companies. Yet even within that pool of 30 million people, only 1-in-5 would take the public option.

Who's likely to sign up?

The budget office said "a less healthy pool of enrollees" would probably be attracted to the public option, drawn by the prospect of looser rules on access to specialists and medical services.

As a result, premiums in the public plan would be higher than the average for private plans. That could nudge healthy middle-class workers and their families to sign up for private plans.

"The concern was that the public option would destabilize the bulk of private insurance, but in fact what Congress has fashioned is very targeted," said economist Karen Davis, president of the Commonwealth Fund. "It's not going to be taking away the insurance industry's core business."

It's unclear whether there are enough votes in the Senate for a public plan.

The version that Majority Leader Harry Reid, D-Nev., has offered would let states opt out, probably leaving a smaller plan that the House would want.

Insurers aren't buying the budget office analysis. Asked if it might soften that opposition, industry spokesman Robert Zirkelbach of America's Health Insurance Plans responded with a curt "No."

While a government plan might start out modestly, insurers fear that Congress could change the rules later, opening it up to all people and setting take-it-or-leave payments for hospitals and medical providers, instead of negotiating, as the House bill calls for.

For the same reason, employer groups also remain wary. Big companies don't want to lose control of their health care budgets and instead have the government send them a tax bill.

"That cost is going to come back to you one way or another ... and it's coming back in the way of taxes and liabilities," said Eastman Kodak's chief executive, Antonio M. Perez, speaking for the Business Roundtable. "We just don't believe that there are miracles out there."

If Congress passes a public plan that's not much of a sensation, Democrats might have reason to regret all the time and energy they invested in it.

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FLEXSPENDING AND HEALTHCARE OVERHAUL

Associated Press –

Nov. 2: Those tax-free spending accounts that you and your co-workers use to help pay for dental work, insurance copayments or over-the-counter drugs face a hit under the health overhaul bills in Congress -- unless a coalition that includes a powerful union, insurers and others can stop it.

Bills in the House and Senate would cap at $2,500 an employee's allowable annual contribution to a health care flexible spending account. There is no federal cap on contributions now, though companies that offer the accounts more than 80 percent of companies employing 500 or more workers do typically impose their own limits, usually around $5,000.

Workers can use the accounts to save pretax income, which then can be used to reimburse a range of medical expenses, including dental and vision costs, prescription and over-the-counter medications and copays and deductibles again without being taxed.

Capping contributions to the accounts would raise more than $13 billion over 10 years to help pay for Democratic health care legislation because it would limit the amount of employees' income that is exempt from taxation.

But an unlikely bedfellows coalition that is characteristic of this health care debate -- where common interests can unite groups that might typically be at odds -- is mobilizing to try to stop the change.

A limited print ad campaign declaring "Flexible spending accounts work!" appeared this past week in Capitol Hill publications. It's paid for by a group called Save Flexible Spending Plans that is backed by insurers, companies that administer consumer spending accounts and other businesses with a financial stake in the outcome. The United Food and Commercial Workers International Union endorsed the campaign and its logo appears on the ads.

"Our concern is that a cap of $2,500 is a definite tax on the middle class, particularly those with chronic illnesses," said Jody Dietel, executive director of Save Flexible Spending Plans. Advocates say the typical flexible spending account user makes $55,000 annually.

Although some lawmakers are sympathetic, the opposition appears unlikely to succeed in getting the flexible spending account cap out of Congress' health care bill. Unlike the initial Senate proposal, though, House members want to allow the cap to be adjusted so it would rise along with inflation. That would be a welcome improvement for advocates.

Aides to the Senate Finance Committee, which proposed the cap, defend it by saying it would help curb overuse of medical care. Money deposited in the tax-free accounts must be used within 2 1/2 months of the end of the plan year.

That may create an incentive for people to spend all the money even if they don't have pressing needs. In addition, committee spokeswoman Erin Shields said the

impact of the cap would be limited. Data compiled by the consulting firm Mercer shows that the average flexible spending arrangement contribution in 2008 was $1,385, much lower than the one contemplated by Congress.

Mercer said that 27 percent of all employers offered health care spending accounts in 2008 -- small businesses are much less likely to do so than large ones -- and that 37 percent of eligible workers signed up for the accounts.

"The provision, in addition to helping reduce the overutilization of care, also affects only a limited number of people," Shields said. Dietel said those averages are no comfort to people using the accounts to cover extreme costs of a chronic condition say a single dad whose child has a peanut allergy requiring special treatment.

"The reality is that an average is an average," Dietel said. "It's the only tool out there that allows an individual to tailor coverage to their own individual need."

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CALIF. DRUG COMPANY SUED OVER ALLEGED KICKBACKS

Ventura County Star -

Oct. 30: New York Attorney General Andrew Cuomo's office announced today that New York and 14 other states have filed a lawsuit against Amgen Inc., alleging the Thousand Oaks-based biotech giant used a kickback scheme to increase sales of its anemia drug, Aranesp. Amgen has received a copy of the complaint and is reviewing it this morning.

Spokesman David Polk issued a statement that the company believes the allegations are without merit. "We look forward to the opportunity to examine these matters with the states before the Court," the statement reads. It added that the company has a "solid compliance program and Code of Conduct" that employees are expected to follow at all times.

Amgen did not comment further because the case is now in litigation. Cuomo's office issued the following release: Attorney General Andrew M. Cuomo today announced that New York and 14 other states are filing a lawsuit against Biotech giant Amgen following an investigation spearheaded by his office into a nationwide kickback scheme to boost drug sales.

In a lawsuit filed today in federal court the states charge drug manufacturer Amgen, International Nephrology Network (INN), a specialty group purchasing organization, and ASD Healthcare, a wholesaler, with offering kickbacks to medical providers to increase sales of Amgen's anemia drug, Aranesp.

"Drugs should be prescribed to patients on the basis of need, effectiveness, and safety, not on a corporate giant's promise of an all-expense paid vacation," said Attorney General Cuomo. "In an egregious violation of the law, Amgen allegedly bribed medical providers and left taxpayers footing the bill for free drug samples. My office's Medicaid Fraud Control Unit will continue to work with our partners in other states to uncover these kinds of abuses."

According to the multi-state complaint, the companies would encourage medical providers to bill third party payers such as Medicaid for free Aranesp that were provided at no cost. Amgen is further alleged to have conspired with INN and ASD

Healthcare to offer illegal kickbacks to medical providers, such as sham consultancy agreements, weekend retreats, or other services to induce them to purchase and prescribe Aranesp with the intention and effect of increasing sales of Aranesp and converting new providers from competitor drugs to Aranesp.

The states involved in the complaint are: California, Delaware, the District of Columbia, Florida, Hawaii, Illinois, Indiana, Louisiana, the Commonwealth of Massachusetts, Michigan, Nevada, New Hampshire, New York, Tennessee, and the Commonwealth of Virginia.

The case is being lead by Special Assistant Attorney General Margot Schoenborn of the Attorney General's Medicaid Fraud Control Unit. The multi-state investigation was coordinated by a team appointed by the National Association of Medicaid Fraud Control Units.

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