



Newsclips

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A Compilation of News Articles on Current Health Issues

GOP governors fight budget lids

T.R. Reid

Washington Post

Mar. 27, 2005 12:00 AM

DENVER - Gov. Bill Owens has been crisscrossing the country for years promoting the virtues of this state's strict constitutional limits on government spending. He has repeatedly urged other states to adopt restrictions of their own, based on Colorado's "Taxpayer Bill of Rights" amendment, known as TABOR.

But this summer, Owens, a Republican, says he'll be traversing his own mountainous state pushing the opposite message. Midway through his second term, Owens is working to persuade Coloradoans to suspend the limits he championed and let the state government spend \$3 billion more in tax money than TABOR would allow.

Owens thus becomes another low-tax, limited-government advocate who has found those principles hard to hold on to amid a sluggish economy and a sharply diminished flow of federal money to the states.

In the past two years, Republican governors, including Nevada's Kenny Guinn, Idaho's Dirk Kempthorne, Georgia's Sonny Perdue and Ohio's Bob Taft have dumped no-new-taxes pledges to push for major new revenue and increased state spending.

Perhaps the most-stinging reversal for tax-limitation groups in Washington was the quick conversion of Mitchell Daniels Jr., who was President Bush's first budget director and an outspoken advocate of lower taxes, until he was elected governor of Indiana in November. In his first state budget, Daniels, a Republican, proposed a 29 percent increase in the income tax, targeted at the upper brackets. Daniels cited a \$250 million revenue shortfall and said spending cuts of that size were untenable.

All of these tax-raising Republicans offer the same basic reasons for their change of heart. "I have done something that is absolutely not part of my fiber," Kempthorne said when he proposed Idaho tax increases in 2003. "But

I'm not going to dismantle this state, and I'm not going to jeopardize our bond rating, and I'm not going to reduce my emphasis on education."

Guinn provided a similar explanation after he pushed through the biggest tax increase in Nevada history.

"Some people say that makes me a bad Republican," the former banker and corporate executive said. "Well, I would be a worse Republican, and a worse grandfather, and a worse citizen, if I didn't find enough money to educate our children and fund our Medicaid program and provide decent prenatal care."

For Owens, as for his fellow GOP governors, a key reason for the tax increases at home has been tax cutting in Washington. Facing sharply decreased revenue and record deficits, Bush has targeted transfers to the states as a ripe place to reduce federal spending. In his budget for fiscal 2006, the biggest single reduction is a \$60 billion cut in Medicaid funds that help the states provide health care to the poor.

"The federal cuts have been very difficult for states to manage," said economist Bert Waisanen of the National Conference of State Legislatures. "Governors have to run programs like Medicaid, No Child Left Behind, homeland security. But there is less and less money coming from Washington to pay the bills."

For all those problems, Colorado hardly seemed a likely state to throw in the towel on spending limits. Among the 30 states that have enacted tax or spending limits, Colorado's was known as the toughest. "When legislators around the country call me to ask about spending limits, they always want to know how it is working in Colorado," Waisanen said.

The TABOR constitutional amendment passed by the voters in 1992 says that government spending levels must be based on changes in population and inflation. Tax in-

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GOP governors fight budget lids continued

creases at any level of government must be approved by a referendum. When tax revenue exceeds the permitted spending level, taxpayers must get a refund the next year; thus the state cannot build up "rainy day funds" in good years.

"The result is the public sector cannot grow at a rate faster than the private sector," Owens wrote in a column for the *Wall Street Journal* praising TABOR.

During the boom years of the 1990s, with population and personal income soaring, the limits worked well. But the economic downturn and the reduction in federal support during the first Bush term proved disastrous for Colorado's finances. The state put off building roads and maintaining infrastructure. It reduced services and raised fees. Spending on higher education fell so sharply that the president of the University of Colorado declared the flagship state school a "private enterprise."

Voters grew increasingly angry and demanded changes from Owens and the Republican-controlled Legislature. But GOP leaders refused to act. "So long as I am governor, we will not raise taxes," Owens said in 2003.

Last fall, the Democratic Party launched a statewide campaign against the TABOR limits, and scored a huge victory at the polls. While Bush was easily carrying the state, Democrats took control of the state House and Senate.

"We have a clear mandate," said Rep. Andrew Romanoff, Democratic leader of the state House. "The voters sent us here to do something about the TABOR roadblock."

Owens conceded the point. On St. Patrick's Day, he agreed to a plan designed largely by Democrats that would suspend the spending limit for five years, allowing the state to spend \$3.1 billion that otherwise would have been refunded to taxpayers.

Because this is considered a tax increase under the TABOR rules, voters must approve the change in November, or it will not take effect. Owens says he will campaign with Democrats

to win voter approval of the anti-limits plan. "This will put Colorado back on track," he said.

Pharmacists' Rights at Front Of New Debate

Because of Beliefs, Some Refuse To Fill Birth Control Prescriptions

By Rob Stein
Washington Post Staff Writer
Monday, March 28, 2005; Page A01

Some pharmacists across the country are refusing to fill prescriptions for birth control and morning-after pills, saying that dispensing the medications violates their personal moral or religious beliefs.

The trend has opened a new front in the nation's battle over reproductive rights, sparking an intense debate over the competing rights of pharmacists to refuse to participate in something they consider repugnant and a woman's right to get medications her doctor has prescribed. It has also triggered pitched political battles in statehouses across the nation as politicians seek to pass laws either to protect pharmacists from being penalized -- or force them to carry out their duties.

"This is a very big issue that's just beginning to surface," said Steven H. Aden of the Christian Legal Society's Center for Law and Religious Freedom in Annandale, which defends pharmacists. "More and more pharmacists are becoming aware of their right to conscientiously refuse to pass objectionable medications across the counter. We are on the very front edge of a wave that's going to break not too far down the line."

An increasing number of clashes are occurring in drugstores across the country. Pharmacists often risk dismissal or other disciplinary action to stand up for their beliefs, while shaken teenage girls and women desperately call their doctors, frequently late at night, after being turned away by sometimes-lecturing men and women in white coats.

"There are pharmacists who will only give birth control pills to a woman if she's married. There are pharmacists who mistakenly believe contraception is a form of abortion and refuse to prescribe it to anyone," said Adam Sonfield of the Alan Guttmacher Institute in New York,

which tracks reproductive issues. "There are even cases of pharmacists holding prescriptions hostage, where they won't even transfer it to another pharmacy when time is of the essence."

That is what happened to Kathleen Pulz and her husband, who panicked when the condom they were using broke. Their fear really spiked when the Walgreens pharmacy down the street from their home in Milwaukee refused to fill an emergency prescription for the morning-after pill.

"I couldn't believe it," said Pulz, 44, who with her husband had long ago decided they could not afford a fifth child. "How can they make that decision for us? I was outraged. At the same time, I was sad that we had to do this. But I was scared. I didn't know what we were going to do."

Supporters of pharmacists' rights see the trend as a welcome expression of personal belief. Women's groups see it as a major threat to reproductive rights and one of the latest manifestations of the religious right's growing political reach -- this time into the neighborhood pharmacy.

"This is another indication of the current political atmosphere and climate," said Rachel Laser of the National Women's Law Center in Washington. "It's outrageous. It's sex discrimination. It prevents access to a basic form of health care for women. We're going back in time."

The issue could intensify further if the Food and Drug Administration approves the sale of the Plan B morning-after pill without a prescription -- a controversial step that would likely make pharmacists the primary gatekeeper.

The question of health care workers refusing to provide certain services first emerged among doctors, nurses and other health care workers over abortions. The trend began to spread to pharmacists with the approval of the morning-after pill and physician-assisted suicide in Oregon, with

support from such organizations as the U.S. Conference of Catholic Bishops and Pharmacists for Life International, which claims 1,600 members on six continents. Its members are primarily in the United States, Canada and Britain.

"Our group was founded with the idea of returning pharmacy to a healing-only profession. What's been going on is the use of medication to stop human life. That violates the ideal of the Hippocratic oath that medical practitioners should do no harm," said Karen L. Brauer, president of Pharmacists for Life, who was fired from a Kmart pharmacy in Delhi, Ohio, for refusing to fill birth control prescriptions.

No one knows exactly how often that is happening, but cases have been reported across the country, including in California, Washington, Georgia, Illinois, Louisiana, Massachusetts, Texas, New Hampshire, Ohio and North Carolina. Advocates on both sides say the refusals appear to be spreading, often surfacing only in the rare instances when women file complaints.

Pharmacists are regulated by state laws and can face disciplinary action from licensing boards. But the only case that has gotten that far involves Neil T. Noesen, who in 2002 refused to fill a University of Wisconsin student's birth control pill prescription at a Kmart in Menomonie, Wis., or transfer the prescription elsewhere. An administrative judge last month recommended Noesen be required to take ethics classes, alert future employers to his beliefs and pay what could be as much as \$20,000 to cover the costs of the legal proceedings. The state pharmacy board will decide whether to impose that penalty next month.

"He's a devout Roman Catholic and believes participating in any action that inhibits or prohibits human life is a sin," said Aden of the Christian Legal Society. "The rights of phar-

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Pharmacists' Rights at Front Of New Debate *continued*

Because of Beliefs, Some Refuse To Fill Birth Control Prescriptions

macists like him should be respected."

Wisconsin is one of at least 11 states considering "conscience clause" laws that would protect pharmacists such as Noesen. Four states already have laws that specifically allow pharmacists to refuse to fill prescriptions that violate their beliefs. At the same time, at least four states are considering laws that would explicitly require pharmacists to fill all prescriptions.

The American Pharmacists Association recently reaffirmed its policy that pharmacists can refuse to fill prescriptions as long as they make sure customers can get their medications some other way.

"We don't have a profession of robots. We have a profession of humans. We have to acknowledge that individual pharmacists have individual beliefs," said Susan C. Winckler, the association's vice president for policy and communications. "What we suggest is that they identify those situations ahead of time and have an alternative system set up so the patient has access to their therapy."

The alternative system can include making sure another pharmacist is on duty who can take over or making sure there is another pharmacy nearby willing to fill the prescription, Winckler said. "The key is that it should be seamless and avoids a conflict between the pharmacist's right to step away and the patient's right to obtain their medication," she said.

Brauer, of Pharmacists for Life, defends the right of pharmacists not only to decline to fill prescriptions themselves but also to refuse to refer customers elsewhere or transfer prescriptions.

"That's like saying, 'I don't kill people myself but let me tell you about the guy down the street who does.' What's that saying? 'I will not off your husband, but I know a buddy who will?' It's the same thing," said

Brauer, who now works at a hospital pharmacy.

Large pharmacy chains, including Walgreens, Wal-Mart and CVS, have instituted similar policies that try to balance pharmacists' and customers' rights.

"We obviously do have pharmacists with individual moral and ethical beliefs. When it does happen, the pharmacist is asked to notify the manager that they have decided not to fill the prescription, and the manager has the obligation to make sure the customer has access to the prescription by another means," said Tiffany Bruce, a spokeswoman for Walgreens. "We have to respect the pharmacist, but we have to also respect the right of the person to receive the prescription."

Women's advocates say such policies are impractical, especially late at night in emergency situations involving the morning-after pill, which must be taken within 72 hours. Even in non-urgent cases, poor women have a hard time getting enough time off work or money to go from one pharmacy to another. Young women, who are often frightened and unsure of themselves, may simply give up when confronted by a judgmental pharmacist.

"What is a woman supposed to do in rural America, in places where there may only be one pharmacy?" asked Nancy Keenan, president of NARAL Pro-Choice America, which is launching a campaign today to counter the trend. "It's a slap in the face to women."

By the time Suzanne Richards, 21, finally got another pharmacy to fill her morning-after pill prescription -- after being rejected by a drive-through Brooks Pharmacy in Laconia, N.H., one late Saturday night in September -- the 72 hours had long passed.

"When he told me he wouldn't fill it, I just pulled over in the parking lot and started crying," said Richards, a

single mother of a 3-year-old who runs her own cleaning service. "I just couldn't believe it. I was just trying to be responsible."

In the end, Richards turned out not to be pregnant, and Pulz was able to obtain her prescription last June directly from her doctor, though she does not think she was pregnant, either.

"I was lucky," Pulz said. "I can sympathize with someone who feels strongly and doesn't want to be involved. But they should just step out of the way and not interfere with someone else's decision. It's just not right."

Pinal County gets medical campus

Jodie Snyder

The Arizona Republic

Mar. 31, 2005 12:00 AM

Banner Health plans to build a medical campus and hospital on 80 acres in fast-growing Pinal County.

The move by the state's largest hospital system shows how quickly the far East Valley area is growing and how hospitals are dealing with the entire Valley's explosive population growth.

It's also welcome news for people who live in areas such as Johnson Ranch. Pinal County residents have to drive up to an hour for medical services.

"Right now, if something happens, you just have to wrap a towel around it and go to the emergency room," said Corrine Cornn, who lives minutes away from the Banner site. "This is great news. They will be in a fantastic location."

The land for the hospital is south of Combs Road on Gantzel Road adjacent to the town of Queen Creek.

Banner plans to break ground in early 2006 for emergency services, diagnostic imaging and ambulatory surgery center. It also will build a medical office building, company officials said Wednesday.

It might build a hospital as early as 2007. The opening date partially depends on the area's population growth, but it's not as simple as reaching a certain threshold, said Carol Freshley, system vice president for planning.

Pinal County has about 250,000 residents and is expected to grow to 1 million people in less than 20 years. The growth has been fueled because the county offers some of the Valley's most affordable housing.

In planning for a hospital, Banner must also know how frequently residents go to hospitals and how much competition is in the area. Freshley said she was not aware of any competitors buying land nearby.

Another factor is the availability of nearby physicians. It takes about two years to build a hospital.

Details are still sketchy about the size of the initial project. Preliminary plans include having an emergency department with five to 10 beds and a one- to two-story medical office building.

Staffing health care facilities is always a challenge, but Banner believes people who live in the area will want to work near home.

The non-profit company has been looking around Queen Creek for as long as three years.

Banner could use the Queen Creek medical campus as a model to be duplicated in other parts of the Valley, said Susan Doria, Banner senior vice president of strategic development. The idea is to build more basic medical services that people need such as emergency care or physician services. Once those are in place, Banner builds the hospital.

In the past, Banner has done it the other way around: built the hospital first and added other services later.

Banner is not the only hospital system on an expansion tear. Three other hospital projects have been announced or are being built, and another hospital chain recently bought property in east Mesa.

Jim Hertel, publisher of the *Arizona Managed Care Newsletter*, says hospitals are trying to strategically position themselves in growing communities.

"The leading hospital players have the wherewithal to begin to build for future growth rather than meeting existing demand," he said.

Medicare Monthly Premium Rising To \$89.20 in 2006

By Ceci Connolly
Washington Post Staff Writer
Friday, April 1, 2005; Page A25

Medicare payments to physicians jumped 15 percent last year, an unexpectedly large increase that prompted Bush administration officials yesterday to announce that monthly premiums for America's seniors will rise to \$89.20 in 2006, \$1.50 more than initially projected.

The unusually sharp spike was caused primarily by lengthier office visits, more complex imaging such as MRI scans and doctors administering more lab tests and treatments in their offices instead of at a hospital.

"There's no question many of these things can help prevent complications of serious chronic diseases and keep patients out of the hospital," said Mark B. McClellan, administrator of the Centers for Medicare & Medicaid Services. But he expressed concern that that is not the case in every instance.

The CMS laid out the costs in a letter yesterday to the Medicare Payment Advisory Commission.

Monthly premiums for Medicare Part B, which covers outpatient services, were \$66.60 last year and rose to \$78.20 for 2005. In its March 23 report, the Medicare Board of Trustees projected an increase of \$9.50 a month, but it now will be \$11.

With increased demand and scheduled reductions in the fees Medicare pays physicians, the American Medical Association warned yesterday that doctors may think twice before taking Medicare patients.

"These cuts pose a serious threat to access to care for seniors," said AMA board Chairman J. James Rohack. "No senior citizen should have to worry whether their physician can afford to accept Medicare patients."

Last year, Congress rescinded a proposed cut in physician payments. But the rates are slated to be trimmed by 4.3 percent next year and by as much as 26 percent through 2011.

As is the case in the private sector, Medicare spending has been rising steadily for the past several years, and its long-term financial solvency is in doubt, according to its board of trustees. Yester-

day's analysis related only to outpatient expenditures.

In a conference call with reporters, McClellan stressed his alarm over the spending figures and said he intends to find ways to steer doctors toward proven, cost-effective treatments. "This is a big increase that has an impact on both beneficiaries and taxpayers," he said.

CMS analysts found that many retirees are seeing doctors more often and for longer periods of time. Payments have been rising for minor treatments such as physical therapy, as well as for injectable medications such as chemotherapy. Government spending for physician services rose from \$76.7 billion in 2003 to \$88.3 billion last year.

Some increase in volume can be good, said Glenn M. Hackbarth, chair of the Medicare Payment Advisory Commission, "but some are not so good." The independent commission, which advises Congress on Medicare, has been pressing for a "pay-for-performance" system that would reward doctors who follow evidence-based treatment guidelines.

The AMA defended the increases, and warned that technological breakthroughs and an aging population will continue to create greater demand.

"Conditions that once required hospitalization now are routinely treated in physicians' offices at a lower cost to the government and patients," Rohack said. "Medicare should recognize and reward these advances rather than penalize physicians for these important improvements in patient care."

Some lawmakers have accused President Bush of focusing on Social Security at the expense of Medicare.

"Medicare's financial outlook has deteriorated dramatically over the past five years and is now much worse than Social Security's," the trustees concluded in their March 23 report. They project that the Medicare Trust Fund will be exhausted by 2020.

Feeding-Tube Benefit Questioned

Experts: Device Unlikely to Prolong Life of Parkinson's Patients

By David Brown
Washington Post Staff Writer
Friday, April 1, 2005; Page A14

Pneumonia caused by inhaling food, liquids or saliva is the most common cause of death in people with long-standing Parkinson's disease, an ailment whose many symptoms include difficulty swallowing.

The placement of a feeding tube reduces the risk of "aspiration pneumonia," but it neither prevents that complication nor appears to prolong life, according to published research and medical experts.

"What people who don't swallow well often die of is pneumonia -- either with or without a tube," said Kathleen M. Shannon, a neurologist and Parkinson's disease expert at Rush University Medical Center, in Chicago.

While pneumonia is the most common cause of death, it nevertheless occurs in only 20 percent to 30 percent of Parkinson's patients. Most of the rest succumb to the common illnesses of old age -- heart attack, stroke, cancer and bloodstream infections.

"My impression is that most people with Parkinson's die like people in the general population," said Carlos Singer, an expert in the disease at the Miller School of Medicine of the University of Miami.

Earlier this week, physicians caring for Pope John Paul II inserted a tube through his nose into his stomach so that he could receive sufficient water and nutrition. Those devices are generally kept in only a week or two, as they are uncomfortable and can cause nose and sinus infections. Patients needing them longer almost always have a larger tube inserted directly into the stomach through the abdominal wall in a simple procedure that can be done under local anesthesia.

The decision to place the nasogastric tube into the 84-year-old pontiff was an ominous sign suggesting that his Parkinson's disease, diagnosed in 1996, was causing life-threatening complications. On Feb. 24, after two hospitalizations for what were described as breathing problems following influenza, the pope underwent a tracheostomy. The procedure created a hole in his windpipe, through which he could breathe with less effort.

Reports from Rome last night said the pontiff had urosepsis, an infection of the bladder and the bloodstream. That, in turn, reportedly caused low and unstable blood pressure, a highly dangerous condition.

By itself, Parkinson's disease does not raise a person's risk of urinary tract infection. However, people immobile in the end stage of the disease sometimes have catheters placed in their bladders -- and those devices increase the chance of infection.

Parkinson's disease causes a slow depletion of several nerve-signaling chemicals called neurotransmitters. A lack of dopamine in the base of the brain, the brainstem, causes the tremors classically associated with the ailment. Loss of other neurotransmitters are responsible for the other two common complications, depression and dementia.

Parkinson's shortens life expectancy but not dramatically. In a group of patients in Minnesota between 1976 and 1995 who were followed by researchers at the Mayo Clinic, survival averaged 10 years, compared with 13 years in a similarly aged group of patients who did not have the disease. In a study from Sweden, a group of patients who had Parkinson's diagnosed in August 1989 was compared to a group of peers who did not have the disease. The average age at death was 82 for the former and 83 for the latter.

How Parkinson's shortens life is not entirely clear.

People suffering from the neurological ailment are less likely than people their age to have hypertension, diabetes and obesity, all of which raise the risk of the cardiovascular diseases that many Parkinson's patients ultimately die of. Some experts believe the inactivity that Parkinson's forces on most sufferers is their main risk factor.

"What it seems to mean is that if you don't have a normal activity level, your life is shorter," Shannon said.

Parkinson's disease disturbs the complicated coordination of muscles that occurs during swallowing and makes many patients less sensitive to foreign substances in their windpipes. Furthermore, their coughs are weaker and less able to clear the material.

A feeding tube helps prevent a person from gagging while eating or drinking. But it does not prevent bacteria-laden saliva and nasal secretions from getting into the lungs and causing infection. In one study, about 20 percent of elderly Parkinson's patients died of pneumonia. In another, the number was 27 percent.

In a 1997 study of nursing home residents with dementia (only some of whom had Parkinson's disease), those who had feeding tubes did not live longer on average than those without them.

Illinois Pharmacies Ordered to Provide Birth Control

New York Times

By MONICA DAVEY

CHICAGO, April 1 - With a growing number of reports of pharmacists around the country refusing to fill prescriptions for birth control and emergency contraception, Gov. Rod R. Blagojevich on Friday filed a rule requiring Illinois pharmacies to accept and dispense all such prescriptions promptly.

"Our regulation says that if a woman goes to a pharmacy with a prescription for birth control, the pharmacy or the pharmacist is not allowed to discriminate or to choose who he sells it to or who he doesn't sell it to," Mr. Blagojevich, a Democrat, said. "No delays. No hassles. No lectures."

Two Chicago women, he said, reported in February that they had been turned away from a downtown drugstore when they tried to fill prescriptions for morning-after birth control pills. On Friday, the Illinois Department of Financial and Professional Regulation filed a formal complaint against that pharmacy, one in the Osco chain, and said it could face discipline ranging from a fine to the revocation of its license. No one from Osco's corporate offices could be reached for comment on Friday.

Nationally, the leaders of Planned Parenthood and Naral Pro-Choice America said they had seen more and more cases like that over the past year. They emphasized that women in smaller communities or in rural areas, with perhaps only one pharmacy to use, might be left unable to receive their prescribed birth control if the pattern was allowed to continue.

"Pharmacies have an ethical and legal obligation," said Nancy Keenan, the president of Naral.

Governor Blagojevich, saying that his emergency rule clarified an existing state requirement, said he suspected that the pattern of complaints over the past year was no coincidence, but rather "part of a concerted effort" to prevent women from getting the birth control they wanted.

Under the emergency rule put in place in Illinois, pharmacies that do not have a particular prescribed contraceptive would be required to order

some or to send the prescription to another pharmacy.

But Susan C. Winckler of the American Pharmacists Association, which represents 52,000 pharmacists, said she had concerns about the emergency rule in Illinois. The association, she said, believes that pharmacists should be allowed to "step away" in cases where they feel uncomfortable dispensing a particular drug - so long as their customers can still get their drugs from alternative sources.

Ms. Winckler said she also worried that Governor Blagojevich's new rule might reach beyond the question of a pharmacist's own moral sensibilities, and require pharmacists to dispense all prescriptions, even those that were "clinically inappropriate" for patients. Such cases might include ones in which a pharmacist discovered a customer's allergy or a potential drug interaction that a prescribing doctor had missed.

"Depending on the wording of the rule, there is a real risk that the governor could be creating," Ms. Winckler said. "The pharmacist is not a gas station attendant where if there is gas you have to sell it. Pharmacists are supposed to assess the appropriateness of a drug."

Abby Ottenhoff, a spokeswoman for Mr. Blagojevich, said the new rule did not take away a pharmacist's right to counsel a patient about a prescription within the confines of existing state law.

"That doesn't change," she said. "What cannot happen is the pharmacist cannot allow personal factors and feelings to interfere."

A Deficiency of D?

By Sally Squires

The Washington Post

Tuesday, April 5, 2005

A new national study finds that most adults, especially those over 50, fall short on recommended daily levels of vitamin D, an essential nutrient long known to preserve bones and now increasingly tied to protection against ailments from cancer to rheumatoid arthritis.

And no, just drinking more vitamin-D fortified milk or juice may not make up the deficit, many experts say, although it can help. Spending 10 to 15 minutes in the sun, done with proper care, might.

The study is based on data drawn from a large, federally funded national health survey and analyzed by a team of scientists from Boston University and private industry. Presented yesterday at the Experimental Biology annual meeting in San Diego, the study found that vitamin D intakes peak during childhood and teenage years and then decline.

Women ages 19 to 50, as well as men and women 51 and older, ate the least food rich in vitamin D. Even when the team accounted for use of vitamin D dietary supplements, few older men and women reached recommended daily levels. The researchers concluded that the low intakes, especially for the aged, "warrant intervention."

At a time when researchers are discovering a widening role for vitamin D, "many lines of investigation indicate that most Americans do not have optimal levels of vitamin D, mainly because of low sunlight exposure," said Walter Willett, chairman of the Department of Nutrition at the Harvard School of Public Health in Boston. Willett convened a meeting in January with leading vitamin D researchers and vitamin manufacturers to review the latest findings. Since there are limited food sources of vitamin D, "the most practical way to increase our vitamin D levels is from supplements," Willett said.

Unlike other essential nutrients, vitamin D is made by the skin, which requires ultraviolet light to produce the vitamin from cholesterol. Those in the Washington area and others who live north of

Newport News, Va., often don't get enough sun exposure year round to make sufficient vitamin D.

Concern over skin cancer means that more people are wearing sunblocks, which inhibit production of vitamin D. Dark-skinned people have to spend up to a couple of hours in the sun to make enough vitamin D. Light-skinned people can get what they need in about 10 to 15 minutes.

The skin's ability to make vitamin D declines significantly with age. For this reason, the National Academy of Sciences (NAS) set the latest vitamin D daily intake on an age-related scale: 200 International Units (IU) -- about the amount found in two eight-ounce glasses of milk -- for those 19 to 50 years of age; 400 IU for those aged 51 to 70 years; and 600 IU for people 70 and older. The NAS also set a tolerable upper intake of 2,000 IU for adults. Toxic levels have been reported at 10,000 IU or higher per day.

But a growing number of scientists believe that vitamin D intake should be at least 1,000 IU or higher.

"Fifty years ago, a bunch of guys got in a room and said, 'We know that a teaspoon of cod liver oil cures rickets in a child and it has 400 IU of vitamin D,' " said Bruce Hollis, a professor of pediatrics, biochemistry and molecular biology at the Medical University of South Carolina. "They transposed that amount onto adults. It was arbitrarily set with no evidence [in adults] at all."

Where research once suggested a limited health role for vitamin D, today there is increasing evidence that it protects against breast, colon and prostate cancer. Population studies show that people with the highest vitamin D levels are less likely to develop multiple sclerosis, lupus, rheumatoid arthritis and other autoimmune diseases than those with lower levels. Plus it appears that vitamin D may protect against heart disease, type 2 diabetes and the insulin resistance that precedes it.

"If just half the chronic diseases laid at the feet of vitamin D pan out, it will be quite significant," said Robert P. Heaney, a professor of medicine at Creighton University in Omaha and a proponent for increasing vitamin D intake.

Just a decade ago, scientists developed an inexpensive blood test that more accurately determines

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A Deficiency of D? continued

vitamin D status. Use of that test revealed widespread deficiencies and led the NAS to note in 1997 that vitamin D "deficiency is now a significant concern in adults over the age of 50 years who live in the northern industrialized cities of the world."

In 2004, the dietary guidelines scientific committee concluded the elderly, people with dark skin and those exposed to insufficient sunlight "are at risk of being unable to maintain vitamin D status" and may "need substantially more than" the 1997 recommendations called for.

But some doctors worry that the evidence is still preliminary. Few if any studies "show that people are having problems with the lower limits of vitamin D being where they are," said New York University dermatologist Darrel Rigel, a past president of the American Academy of Dermatology.

Dermatologists are particularly concerned that raising the vitamin D recommendation might tempt some people to spend more time in the sun or in tanning booths, thus increasing their risk of skin cancer. "Our recommendation is to take either vitamin pills or eat food that we know has higher levels of vitamin D," rather than increase sun exposure, said Henry Lim, chairman of dermatology at the Henry Ford Hospital in Detroit.

Here's how to boost vitamin D levels safely:

Drink vitamin D fortified beverages. While diet alone is unlikely to get you to the levels needed, drinking milk and other vitamin D fortified beverages will help. Some juice and soy milk is also fortified. An 8-ounce glass of any of these beverages delivers about 100 IU, or about half the intake recommended daily for adults 19 to 50 years of age; a quarter of the amount for adults 51 to 70; and just a sixth of the intake for those 70 and older. Yogurt and cheese are not fortified with vitamin D.

Eat more herring and sardines. An ounce of pickled herring has nearly 200 IU of vitamin D. Two small sardines have 65 IU. But not all fish contains vitamin D. Salmon and tuna, for example, have none.

Breakfast on fortified cereal or cereal bars. A cup of vitamin D fortified cereal delivers about 40 to 60 IU of vitamin D. Fortified cereal bars have even less: about 30 IU per bar.

Take a multivitamin or other supplement. Most multivitamins, even the ones aimed at seniors, provide 400 IU of vitamin D, which won't cover those 70 and older. Some vitamin and health food stores sell gelcaps of vitamin D supplements that range from 700 IU to 2,000 IU. "The most practical way to increase our vitamin D levels is from supplements," said Harvard's Willett.

Fun in the sun. Fifteen minutes of peak sun exposure without sunscreen allows a light-skinned person to make about 20,000 IU of vitamin D, according to Hollis. But much of that dose quickly "goes away," he said. You'd need such exposures at least every few days in order to sustain adequate levels. Since regular sun exposure increases skin cancer risk, "it's okay to expose yourself a little to the sun," said Henry Ford's Lim, "but not too much."

Hundreds Have Been Hired to Provide New Medicare Drug Benefit

Washington Post

By Stephen Barr

Wednesday, April 6, 2005; Page B02

It's one of the biggest benefit programs ever launched by a federal agency. It's happening on a fast track. And it's going to require new employees who are quick learners.

The Medicare program will offer a prescription drug benefit to the nation's seniors at the start of next year, an ambitious effort that will require focused management and skilled employees in order to succeed.

Yesterday, the head of the Centers for Medicare & Medicaid Services reassured a Senate subcommittee that the agency is on track to deliver the drug benefit, noting that 345 new employees have been hired to provide the expanded services.

"CMS is confident that, throughout the country, beneficiaries will have access to prescription drug plans on schedule," **Mark B. McClellan**, the agency's administrator, told a Senate subcommittee on government management and the federal workforce.

McClellan said CMS has revamped its hiring process and realigned its operations. It also is building a staff that will have expertise in drug benefits, pharmacy services, disease management, retiree health benefits and contracts, he said.

CMS plans to hire an additional 55 employees for the drug benefit program over the next few months, bringing the number of new hires to 400. The agency has estimated that it will need at least

500 new employees to meet the goals laid out in the 2003 Medicare modernization law.

In a statement accompanying his testimony, McClellan said the agency has taken advantage of hiring flexibilities authorized by Congress as part of the law. CMS has used "management staff" authority to give higher salaries to certain types of experts who are in high demand in the private sector, "direct hire" to make speedy employment offers, and the federal career intern program to bring in people on two-year internships that typically lead to a permanent civil service job.

The majority of the new hires -- 251 -- have come through the direct hire and intern programs, the statement said. Twenty of those hired have been at the top of the federal pay scale, General Schedule 15 and above.

According to CMS, 36 percent of the 345 new employees came from the private sector, while 33 percent transferred from elsewhere in CMS to take in the prescription benefit program. An additional 15 percent were hired from other government agencies.

The remaining employees came from nonprofits, state and local governments and academic institutions, CMS said.

The hearing was held by Sen. **George V. Voinovich** (R-Ohio), who chairs the Senate subcommittee on government management and the federal workforce. Five Democrats joined Voinovich at the hearing, asking a series of skeptical questions about the drug benefit. Some Democrats expressed fears that poor Americans might end up with less drug coverage than they currently receive through Medicaid.

In addition to hiring for the Medicare program, CMS is reviewing its overall employment practices. Last year, CMS volunteered for an "Extreme Hiring Makeover" project, which is being coordinated by the nonprofit Partnership for Public Service.

Marcia Marsh, a vice president at the Partnership, said the project is looking at ways to streamline and improve hiring. The project team found that CMS usually goes through 64 steps in hiring and is looking at ways to cut steps and speed the process, she said.

The project team also ran a demonstration to experiment with new approaches to hiring. The current method typically produces 53 applicants for every job, while the experiment reeled in 227 applicants. The experiment featured announcements that touted the advantages of CMS jobs and a targeted e-mail campaign, which identified possible applicants based on résumés they had placed on Internet job boards.

Of those who passed an initial screening, 169 agreed to take a 45-minute "skills test." CMS selected 24 of the applicants for job interviews. The top-scoring applicant was a disabled veteran, Marsh told the subcommittee. The veteran and five others have been offered jobs, she said.

Firms Say They'll Help Poor Get Medicines

By KEVIN FREKING
The Associated Press
Wednesday, April 6, 2005; 1:26 PM

WASHINGTON - Drug manufacturers, under fire from consumer advocacy groups for opposing legislation to reduce prescription costs, announced Tuesday they would spend about \$30 million through June to develop and promote a program that would help poor Americans gain access to the medicines they need.

Throughout the country, hundreds of public and private programs already provide some assistance to consumers who can't afford their prescriptions. But finding out about the programs and accessing them can be a daunting bureaucratic task for doctors, let alone consumers.

The new program establishes a Web site and calling centers to match consumers with the program that best suits their needs. The drug manufacturers' partnership is spending \$10 million to promote the campaign. It took out full-page advertisements Tuesday in several large newspapers and will also air television ads.

In addition, more than \$20 million will have been spent developing the program and running three call centers through the end of June, the program's organizers said.

Drug manufacturers have been criticized for their opposition to legislation designed to reduce the cost of prescriptions through such measures as allowing drugs made in the United States to be imported from countries where the drug is available at a lower cost.

"This is serious business. This is going to be very expensive for the companies, but they're willing to make this commitment to save the free-market system in America," said Billy Tauzin, a former House committee chairman who is now president and CEO of the Pharmaceutical Research and Manufacturers of America.

Consumers can access the Partnership for Prescription Assistance program by calling a toll free number - 1-888-477-2669, or through the Internet at <http://www.pparx.org>.

Ron Pollack, executive director of Families USA, an advocacy group that is often at odds with drug manufacturers, said some charitable programs of-

fered by the drug companies are helpful to consumers. Others are marketing tools designed to build allegiance to a specific drug.

"It clearly is a public relations response to the widespread criticism concerning the skyrocketing prices that the drug companies continue to charge and to put as warm a face as possible on these growing problems," Pollack said. "How much of this will result in meaningful help to the people priced out of their medicines and how much of this results only in window-dressing is as yet unclear."

The federal government will provide prescription drug coverage next year for the first time under Medicare, but Tauzin said millions of uninsured Americans will still need help paying for their medicine. The program will probably expand in coming years, even with the new government benefit, he said.

Some Democratic lawmakers were not impressed with the new program.

"Helping a subset of the public navigate a patchwork of assistance programs is not a solution, it's a stalling tactic," said Rep. Sherrod Brown, D-Ohio. "The best way to help Americans is to charge us fair prices in the first place."

"The effort of the pharmaceutical companies is helpful, but insufficient," said Rep. John D. Dingell of Michigan, the senior Democrat on the Energy and Commerce Committee.

Sen. Charles Grassley, R-Iowa, chairman of the Senate Finance Committee, gave the program a lukewarm endorsement.

"The drug industry is right to recognize that many Americans don't know where to turn for help with skyrocketing prescription drug costs. I don't know how much this program will help, but surely it can't hurt," Grassley said. "In the meantime, I'll continue to support drug importation as a way to cut costs for American consumers."

Dozens of organizations, such as Easter Seals, the United Way of America, and the American Academy of Family Physicians, are listed as partners with the drug manufacturers in the new program. The manufacturers, however, provide the financing.

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Firms Say They'll Help Poor Get Medicines *continued*

Dr. Mary Frank, president of the Academy of Family Physicians, said she had no idea so many programs existed in the public and private sector to help patients afford their medicine. The partnership puts 1,200 medications, including generics, under one access point, she said.

"This will give our patients access to so many more (medicines)," she said.

Miles White, CEO of Abbot Laboratories, said drug companies decided about 18 months ago that they needed to alter their agenda from advocacy to solving problems of affordability. Their answer was a clearinghouse designed to eliminate so much of the confusion about the myriad programs available to the poor as well as to those suffering from a specific type of disease.

Tauzin said the companies would continue to oppose legislation that they believe would place less emphasis on free markets and more emphasis on government price controls.

"The reason why PhRMA supports the free-market system is that it's the last bastion that rewards innovation," Tauzin said. "But we realize that if we're going to retain that system, we can't leave people out simply because they're impoverished."

Md. Passes Rules on Wal-Mart Insurance

Bill Obligates Firms On Health Spending

By John Wagner and Michael Barbaro
Washington Post Staff Writers
Wednesday, April 6, 2005

Maryland lawmakers yesterday approved legislation that would effectively require Wal-Mart to boost spending on health care, a direct legislative thrust against a corporate giant that is already on the defensive on many fronts nationwide.

"We're looking for responsible businesses to ante up . . . and provide adequate health care," said Sen. Thomas M. Middleton (D-Charles), the Finance Committee chairman, as the Senate approved the measure with a majority wide enough to survive an anticipated veto. A similar bill has cleared the House of Delegates, and legislators expect to reconcile their differences easily.

Lawmakers said they did not set out to single out Wal-Mart when they drafted a bill requiring organizations with more than 10,000 employees to spend at least 8 percent of their payroll on health benefits -- or put the money directly into the state's health program for the poor.

But as debate raged in the Senate yesterday, it was clear that the giant retailer, which has 15,000 workers in Maryland, was the only company that would be affected.

"This is crossing a bridge," said Sen. E.J. Pipkin (Queen Anne's), who joined the Senate's other Republicans in voting against the bill. "Annapolis is telling private business in the private marketplace what to do."

Wal-Mart officials, likewise, condemned the General Assembly's effort as an unneeded intrusion. "We think that this sets a bad precedent by singling out one employer when it's a much bigger issue," said Nate Hurst, a government relations manager at Wal-Mart.

The retailer already is dealing with a spate of bad publicity, including increasingly intense criticism of its labor practices and a series of lawsuits. In the past month, the company agreed to pay \$11 million to settle claims that one of its cleaning contractors hired illegal immigrants, and Vice Chairman Thomas M. Coughlin resigned after an internal probe questioned his use of as much as \$500,000 in com-

pany funds.

The company is also battling a sex discrimination complaint filed by current and former female employees.

Along with tarnishing the folksy image fostered by founder Sam Walton, that sort of publicity could hurt the company's ability to add stores and could lead other states to pursue legislation similar to that advancing in Maryland, company officials said.

Despite its more than 5,000 stores and \$285 billion in sales worldwide, Wal-Mart's future is closely tied to continued expansion. In the past year, the retailer has lost battles to build stores in Inglewood, Calif., Chicago and New York City. At the same time, dozens of local governments -- including Calvert, Prince William and Montgomery counties in the Washington region -- have passed zoning rules making it difficult for Wal-Mart to pursue its plans.

To battle back, the company has launched an unprecedented public relations campaign -- with advertisements in such publications as the New York Review of Books and face-to-face meetings with students, environmentalists and members of the Congressional Black Caucus -- aimed at tempering the company's skinflint reputation.

This week, the company hosted more than 50 print journalists from the United States, Japan and Britain at its Bentonville, Ark., headquarters.

Company officials said yesterday that they have let their critics, including labor unions, set an agenda that has focused legislative and regulatory attention on the company.

"We did a disservice to our employees and shareholders" by not speaking up, Wal-Mart chief executive H. Lee Scott Jr. said.

"Many of our competitors, let's face it, would like to continue to be rewarded for operating in ways that are less efficient," Scott said, adding that criticism of the company's wages and benefits from grocery workers' unions neglects to account for the fact that its low prices help working families.

(Continued on page 16)

Md. Passes Rules on Wal-Mart Insurance *continued*

Wal-Mart's image problems have had no measurable impact on consumers' willingness to shop at the chain, analysts said. Sales grew 11 percent last year and Wal-Mart estimates that 90 percent of Americans, or 270 million people, shopped at one of the company divisions in 2004.

Still, critics abound. At least two dozen Web sites catalogue the chain's missteps. One, the Wal-Mart Litigation Project, describes itself as a guide for lawyers preparing to sue the company. At another site, "Wal-Mart Fact Checker" rebuts company advertisements line by line.

And last week, 21 Democratic members of the U.S. House joined the United Food and Commercial Workers International Union in calling on ABC News to drop Wal-Mart as a sponsor of a "Good Morning America" series called "Only in America." ABC said it will stick with Wal-Mart.

"There is no perceived risk in attacking Wal-Mart anymore," said Eric Dezenhall, president of Dezenhall Resources in Washington and a veteran corporate crisis expert. "They have gone from being a business success story to being a cultural villain."

In Maryland, Gov. Robert L. Ehrlich Jr. (R) is expected to lend his support to the retailer and veto the measure, should the House and Senate reconcile small differences in the bill.

"I don't think this is a bill the governor is inclined to support," Ehrlich spokeswoman Shareese DeLeaver said yesterday, citing the governor's unabashed pro-business posture. Late last year, Wal-Mart hosted an Annapolis fundraiser for Ehrlich, which DeLeaver said is irrelevant to his thinking.

The margin of yesterday's Senate vote would be sufficient to override a veto. The House vote last month fell one vote short of a veto-proof majority, but several members were absent. Advocates predicted that they would have enough support to outflank the governor.

"This bill is going to become law with or without Bob Ehrlich," said Vincent DeMarco of Maryland Health Care for All, a coalition of labor, religious and community groups that pushed for passage of the bill.

DeMarco said the bill did not aim solely at Wal-

Mart. Johns Hopkins University, Giant Food and defense contractor Northrop Grumman Corp. have enough employees to fall under the bill's requirements. But all meet the 8 percent threshold for for-profit employers or the 6 percent mandated for nonprofits.

It was unclear yesterday exactly how far Wal-Mart is from the 8 percent mark.

Lawmakers said the company told them a year ago that it spent about 5 percent of its payroll on health benefits, which would mean an investment of roughly \$8 million. Hurst, the company spokesman, said yesterday that the figure is 7 to 8 percent.

Hurst said about 80 percent of Wal-Mart workers in Maryland are eligible for benefits. Of those, he said, more than 52 percent have enrolled in health care options the company provides.

Middleton, the Senate Finance Committee chairman, said he hoped that, faced with the choice, Wal-Mart would spend the money on its own employees rather than contribute to the state Medicaid program.

"I think they would be crazy not to," he said. "This is an incentive to invest in their health care."

Ethics Panel Finds Conflict With Senator's Job as Physician

By Jeffrey H. Birnbaum
Washington Post Staff Writer
Wednesday, April 6, 2005; Page A05

For years, Republican Tom Coburn juggled his duties as a House member and a family physician back in Oklahoma, where he delivered dozens of babies annually.

But since winning a Senate seat last fall, Coburn has clashed with Senate ethics committee members over whether he could continue to do double duty as a lawmaker and an obstetrician. Now, Coburn says, the ethics committee has ruled that his private practice constitutes a potential conflict of interest with his work in Washington, and it has given him until Sept. 30 to close his office in Muskogee, Okla. An outraged Coburn is vowing to fight the ruling, arguing that the panel's decision contradicts the Founding Fathers' desire for lawmakers to retain ties to their communities.

In an interview yesterday, he vowed to seek the backing of sympathetic grass-roots groups to try to persuade the panel to alter Senate rules and open the way for doctors in the Senate to see patients for pay.

"My hope," he said, "is to get a rules change that will allow me to continue to practice medicine."

Coburn and Senate Majority Leader Bill Frist (R-Tenn.) are the only senators who are physicians. For nearly two decades, Senate rules have barred members from holding outside professional jobs, such as those as lawyers, real estate agents and physicians, for fear that such services -- and compensation for those services -- might conflict with their role as policymakers. The Senate panel refused Coburn's request to grant him a special exception once he closes his business.

The decision is a blow to the freshman who pledged at almost every campaign stop last year to serve as a citizen legislator -- a senator in Washington and an obstetrician-gynecologist at home.

The maverick conservative won election to the Senate last November after a bitter battle with Democrat Brad Carson. Coburn's medical practice became an issue when he was accused of sterilizing an underage woman without her consent. Coburn denied the charge and called it a smear tactic by his opponent.

Last December, the chairman and vice chairman of the Senate ethics panel warned Coburn in writing that long-standing rules prohibit senators from receiving compensation for various professions, including a medical practice. The committee asked Coburn to shut down his practice by the time he was sworn in.

In response, Coburn, 57, stopped accepting new patients "to comply with the spirit" of the request and began negotiating with the committee to waive the rules in his

case. Meanwhile, he has continued to see patients and deliver babies in technical violation of those rules.

Coburn argued that the nation's founders envisioned that legislators would continue to function as citizens in their communities, including as doctors. He said that he wanted to make only enough money as a doctor to cover his expenses, and that working as a physician does not pose the same kind of potential conflicts of interest that being a lawyer might.

He said that he has a duty to his patients, many of whom are indigent, and that he needs to continue his practice to maintain his skills and his medical license.

"I am currently caring for many high-risk patients including some who have multiple sclerosis and other debilitating conditions," Coburn wrote the committee. "I simply cannot abandon those patients. I trust that the committee can imagine how abruptly terminating my practice would violate my medical ethics."

While Coburn served in the House from 1995 to 2001, that chamber's ethics committee allowed him to practice medicine provided he did not receive net income beyond his expenses.

But Senate ethics rules do not differentiate between net and gross income, and the Senate panel concluded on March 18 that physician-lawmakers are barred from taking any money from patients regardless of expenses.

Sen. George V. Voinovich (R-Ohio), the ethics panel's chairman, and Sen. Tim Johnson (D-S.D.), its vice chairman, informed Coburn by letter that "it would not be possible, prudent or fair" for the panel to reconsider or reinterpret the rules, which have been in place since 1977.

The original rules were written during the reform-minded period after the Watergate and South Korea influence peddling scandals when lawmakers were cracking down on their own conflicts of interest and other possible ethical lapses.

The Senate committee did agree to Coburn's request, conveyed by J. Steven Hart, his attorney, to allow the senator to take nine months to close shop, enough time to see his pregnant patients to term.

Coburn said that he will continue to treat patients until the end of the year, but, in line with the ethics panel's decision, will not take any payment from them after Sept. 30.

In the meantime, he said, he intends to "live by the rules" but added that "I would love to enlist anybody's help that I can to put a balanced perspective on the issue."

Experts weigh in on health care Rx

No shortage of solutions

Jodie Snyder

The Arizona Republic

Apr. 7, 2005 12:00 AM

Rising health care costs threaten the American economy, but there is no shortage of prescriptions among experts to address the problem:

Health savings accounts could make patients cost-conscious because they could roll over unspent money for future care.

Doctors could be held more accountable for medical quality and costs.

Patients could obtain cost comparisons as easily as cash from an ATM.

Those were among the suggestions offered from experts ranging from Nobel Prize winners to leading politicians Wednesday at a national health care symposium sponsored by Arizona State University.

About 200 business people, health care providers and students attended the "Transforming American Healthcare Over the Next Decade: Pathways to Change" symposium, sponsored by the W.P. Carey School of Business, at the Arizona Biltmore Resort & Spa.

The symposium's goal was to look at how to control double-digit increases in health care costs and improve medical quality in the face of an aging population and technological advancements.

Edward Prescott, the ASU professor who won the 2004 Nobel Prize for economics, stressed that free-market economics should guide the health care system. One possible solution: health savings accounts, in which people often pay a high deductible but can roll over money not spent that year on medical care.

The current system, which relies on third-party payers and government funding, is inefficient, he said.

Third-party reimbursement encourages people to go to doctors unnecessarily or get unneeded tests because patients don't pay the

true costs; their employers do.

The public funding system is inefficient because it will require larger tax increases to cover increasing costs, Prescott said. Those tax increases will discourage American workers from putting in more hours at work, he said.

But setting up health savings accounts won't really solve surging health care costs, said Dan Crippen, former director of the Congressional Budget Office.

About 25 percent of Medicare patients account for 95 percent of the program's costs. Making those patients more responsible for their health care costs won't change their expensive, chronic conditions, he said.

These patients rely on their physicians for guidance on tests to get and drugs to use. It's physicians' behavior that needs changing, not patients', Crippen said.

However, Newt Gingrich, former speaker of the U.S. House of Representatives, was adamant that people must know the costs of their own care and be more responsible for them.

"No one ever washes a rental car," he said, saying people who rely on their insurers to pay for their care have no financial incentive to stop smoking or to eat better.

Gingrich, who has founded a health care think tank, strongly suggested that health care leaders look to other industries for ways to decrease costs and improve quality.

Why can't making doctors' appointments be as easy as getting money from an ATM? he asked, saying the same technology is involved in both transactions.

He also asked why information about costs and alternatives to specific prescription drugs couldn't be posted on the Internet, just like Travelocity.com does with airplane and hotel deals.

He also asked why there isn't a more coordinated effort to reduce medical errors, which

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Experts weigh in on health care Rx continued

lead to more than 32,000 U.S. hospital deaths and more than \$9 billion annually in extra costs.

The medical industry could learn from the airlines, which have pilots follow a standard flight-operations checklist and conduct exhaustive reviews when planes crash.

George Poste, director of the Biodesign Institute at ASU, agreed with Gingrich on using more technology to improve the quality of medicine. He cited the importance of electronic records and evidence-based medicine, which relies on crunching data to determine what works best for the most patients. Some doctors have resisted it, describing the move as "cookbook medicine."

"The cry is for evidence of outcomes," Poste said. "This is a tidal wave that physicians can't stop."

Medicaid Accounting Tactic Is Criticized by Lawmakers

States Defend Method as Means to Get Health Care Funding

By Jonathan Weisman
Washington Post Staff Writer
Friday, April 8, 2005; Page A23

This year, as they have done for many years past, California officials will use an accounting strategy that will yield nearly \$2 billion more in federal Medicaid payments than the state might otherwise be entitled to.

The accounting gambit, which is drawing increased scrutiny in Washington, goes something like this: California's cash-strapped counties, public university system and government hospitals scrape together \$1.9 billion to send to Sacramento, ostensibly as a local contribution to the Medicaid health program for hospitalization and the uninsured. That money is then returned to the localities, but state bookkeepers continue to carry the funds on their balance sheet. Then the state asks the federal government to provide matching funds, not only for the state's Medicaid expenditures but also for those local contributions.

By so doing, California will increase its federal Medicaid match by nearly 9 percent -- a boon to the Golden State at the expense of the federal taxpayer.

"They're basically money-laundering," charged Jim Frogue, state project director of former House speaker Newt Gingrich's new Center for Health Transformation.

States have used this bit of creative accounting for more than a decade, with the knowledge and approval of the federal government. But this year, such tactics are at the heart of the biggest budget battle in Washington, one that has pitted the Bush administration against the nation's governors and the Senate against the House.

The White House and its allies in Congress say the federal government could save as much as \$20 billion over the next five years by clamping down on what they see as fraudulent or abusive budget gimmickry. They began pressing their case this week when the House and Senate budget chairmen met to work out a compromise budget resolution that singles out Medicaid for the largest reductions.

But the states and their allies from both parties say their long-standing tactics are critical to providing medical services to indigent people.

"It's easy to label something as fraud and abuse," said Anne Marie Murphy, the Illinois Medicaid director. "But the reality is, these dollars go to health care."

On Wednesday night, Republican Sens. Gordon Smith (Ore.), Norm Coleman (Minn.), Olympia J. Snowe (Maine) and Lincoln D. Chafee (R.I.) told Senate Majority Leader Bill Frist (R-Tenn.) that they were holding firm on their stand that a high-level Medicaid commission must be convened before they could accept any cuts to the program's growth. Senate Budget Committee Chairman Judd Gregg (R-N.H.) has been just as uncompromising in his push to restore \$14 billion in Medicaid cuts that a Senate majority stripped from his budget last month.

"If you go below \$14 billion, you're basically admitting you're not going to do anything substantive," he said.

The dispute has all but ended hope that a budget can be completed by the budget committees' April 15 target, budget aides said yesterday. It could derail the budget altogether.

"I don't know how we get a budget that does Medicaid, given the Senate vote," Gregg said, "but I don't see a point in doing a budget without it."

With coverage reaching 53 million people, or 18 percent of the U.S. population, Medicaid is now considerably larger than Medicare, the health insurance program for the elderly. Federal spending on Medicaid is projected to rise 41 percent over the next five years, from \$186 billion this year to \$262 billion in 2010.

For states, however, the crisis is now. This fiscal year, 47 states and the District of Columbia will cut payments to health care providers, according to the Henry J. Kaiser Family Foundation. Fifteen states will throw people off the Medicaid rosters, and nine will cut benefits for those who remain eligible.

Given those strains, any reduction in federal matches will hurt, state Medicaid directors said.

"If we lost the \$1.9 billion, it would be devastating. That would close virtually all the hospitals in California," said Stan Rosenstein, deputy director of

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Medicaid Accounting Tactic Is Criticized by Lawmakers

States Defend Method as Means to Get Health Care Funding **Continued**

medical care services for the California Department of Health Services.

State Medicaid officials are not shy about their creativity. "As state Medicaid director, I'm obligated to find as many federal dollars as I can, as long as it's legal," said David Feinberg, deputy secretary of Pennsylvania's office of medical assistance.

Through taxes on hospitals, insurance companies and, next year, possibly physicians, Michigan has been able to boost its federal contributions without increasing the state's share, said Paul Reinhart, the state's Medicaid director.

"Admittedly we use and continue to use unorthodox payment options," Reinhart said.

In Illinois, Chicago's Cook County adds \$1.1 billion to the \$1.4 billion the state spends on the county's public hospital system, boosting the federal match for the county to \$2.5 billion.

In Pennsylvania four years ago, administrators calculated that the difference between their county nursing home costs and the maximum amount payable under federal law totaled \$1.6 billion. So they had 20 county nursing homes go to their banks to borrow \$1.6 billion, which was then sent to Harrisburg. The money was returned, but not before the state extracted an additional \$850 million from the federal government.

For years, Iowa banked unused federal Medicaid dollars in a fund that the state used for indigent health care when budgets were tight. In effect, Iowa was using federal money to boost its federal match, reducing the state's Medicaid share from the statutory 34 percent to as little as 22 percent, said Kevin W. Concannon, director of the Iowa Department of Human Services.

Under pressure from the federal government, Iowa agreed last month to give up the \$66 million scheme in exchange for an increased federal allotment of the same size. The state will also forgo a nursing home tax that is costing Washington millions more, Concannon said.

Indeed, Iowa and the federal Centers for Medicare and Medicaid Services see the Iowa agreement as a model for other states. Under the waiver, not only will Iowa drop its creative accounting but the Bush administration also granted Gov. Tom Vilsack (D)

broad new powers to reduce Medicaid costs, for Iowa and the federal government.

Setting aside a federal requirement that Medicaid be available statewide, Iowa will be allowed to expand health coverage for the uninsured but limit their access to three general hospitals and four psychiatric hospitals. The state was granted permission to tighten eligibility requirements for nursing home coverage, but liberalize access to cheaper alternatives, such as home nursing care, elder day care centers and temporary respite care to give family caretakers a break.

The Iowa agreement underscores a strongly held contention among GOP budget writers that states could easily absorb a clampdown on their accounting tactics if they are given more flexibility to hold down costs. As it stands, the main options governors have to save money now is to cut services or throw Medicaid recipients off their rosters.

"Any governor who's worth his salt as a manager, you give him more flexibility with even these dollars, they'll be able to give more services to more people," Gregg said.

But Medicaid directors are firmly against Gregg's approach. The cuts in the budget committees' original spending plans appear to be arbitrary budget targets, not figures based on the savings available, Concannon said.

California's Rosenstein agreed. "I think every governor, including Arnold Schwarzenegger, believes Medicaid needs to be reformed," he said. "But we should decide the policy first, then see what savings that policy generates."