TRENDS & Ideas

HEALTH PLANS

When to Pay for Expensive Medical Innovations

Medical advances have been growing at a rapid rate, and many of them carry expensive price tags. That has turned into a double-edged sword for those who manage healthcare dollars, according to *Business & Health* magazine.

Health plans trying to spend money wisely walk a difficult financial tightrope. They do not want to waste funds on less-than-optimal treatment, nor do they want to withhold resources from beneficial procedures. And the stakes can be high. Earlier this year, jurors in California ordered Aetna U.S. Healthcare to pay $120.5 million to a widow for refusing to cover an experimental stomach cancer treatment advised by her husband's doctor.

Little is known about how—or even if—plans use economic evaluations, primarily because "it's dangerous to say you're not covering something because of cost," according to Peter Neumann of the Program on Economic Evaluation of Medical Technology at Harvard University's Center for Risk Analysis. Cost is a significant factor, of course, because many health plans are eager to jump on the bandwagon when an innovation will slash expenses. Many were quick to adopt a new test to detect an ulcer-causing bacterium for about one-fourth the cost of the previously used biopsy. When the bottom line is less certain, plans are often more reluctant to get on board.

In a perfect world, decisions on which new procedures receive coverage and which do not should be based on evidence, but that is easier said than done. Plans have technology assessment systems to evaluate new innovations, but these assessments vary wildly, and many plans are "making [coverage] decisions by the seat of their pants," Neumann said. For example, regardless of the evidence concerning effectiveness, plans will offer alternative therapies because they have proven to be good marketing tools. They also will bow to prevailing medical practice, continuing an old standard over a new and more cost-effective treatment in communities where the older technology remains the norm.

Adding a further complication, the Internet has made consumers more knowledgeable. About 60 million Americans went to the Internet for health information in 1998, according to a Harris Poll, with 90 percent saying their research was useful. However, some of these patients will insist their plans pay for questionable medical approaches their doctors would never choose for first-line therapy. One study of HMO dispute resolution in California found that plans routinely override denials when patients object and the dollar amount is not very high.

TECHNOLOGY

Wheelchairs: Onward and Upward

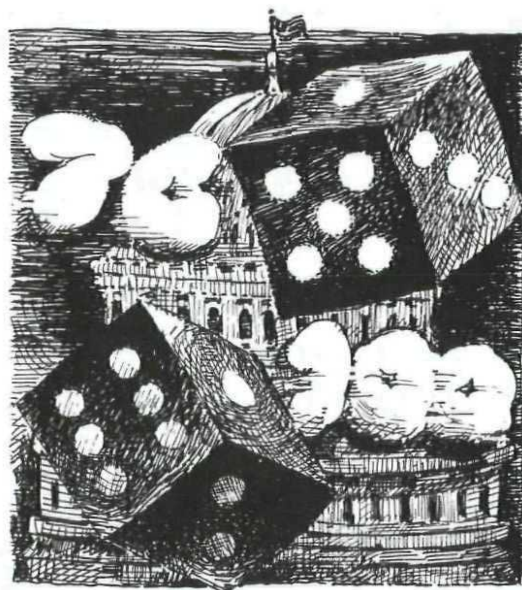
Innovations in wheelchair design and technology have the potential to transform the lives of some of the 1.5 million people with spinal-cord injuries, multiple sclerosis, and other mobility problems, says the *Wall Street Journal*. Wheelchairs are now available that can climb curbs and negotiate off-road terrain, and one model in testing uses gyroscope technology combined with sensors that constantly monitor body movement to enable a seated occupant to raise the wheelchair and balance on two wheels. This breakthrough will allow wheelchair users to do many simple things others take for granted: reach items in the grocery store, take a book off a library shelf, talk to people at eye level.

Clinical trials for the device, which is being developed by Johnson & Johnson and is known as the IBOT, have begun under Food and Drug Administration–approved protocols. People will use it in their homes and neighborhoods, riding along sidewalks and into stores. Johnson & Johnson hopes to win approval to market the vehicle by the end of next year or the beginning of 2001.

The IBOT's sensors send 10,000 instructions a second to its onboard computer so it can instantly respond, particularly when up on two wheels, to any movement of the body and stay balanced. It also has a rotating four-wheel-drive wheelbase that gives it climbing capability and the power to move through sand and grass and over rocky terrain. Backup technology reduces the risk of injury if components fail.

With a price tag of $20,000 to $25,000, the IBOT may be out of the reach of many who could benefit from it. But insurers may be convinced to cover its cost, since it can improve quality of life and enable people to return to work or be more productive in their current jobs. Wheelchair activists point out, however, that communities and employers still need to provide access around barriers that hinder people with disabilities.

Illustrations by Sim Gellman



DEMOGRAPHY

U.S. Betting against Longer Life

Most Americans are familiar with debates about the long-term viability of the Social Security trust fund. But what if average life expectancy were to jump from the current 76 years to 100 years? A change like that would certainly strain the fund, writes David Stipp in *Fortune*. And, he says, some scientists think the jump has already occurred.

Demographers like James Vaupel note that, in the 20th century, average life expectancy has undergone three stages: It rose quickly through the 1950s, primarily because a combination of factors (including antibiotic medicine and improved nutrition) slashed mortality among young people. Following those gains, the average life span seemed to hit a plateau in the 1960s and '70s. Then, around 1980, it appeared to climb again.

Vaupel, an American who directs Germany's Max Planck Institute for Demographic Research, describes this third stage as the result of "mortality deceleration" in older persons. Although the causes for it are unclear, the evidence indicates that in some developed nations the number of centenarians has doubled every decade since about 1970. Vaupel predicts that, among people born in the developed world since the mid-1980s, half of the females and a third of the males will live to be 100.

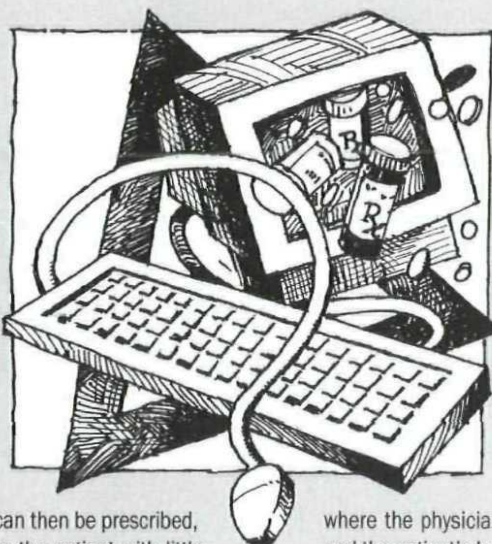
Such views are scoffed at by demographers like the University of Chicago's Jay Olshansky, who says, "The practical limit for life expectancy hasn't changed at all. It's still about 85." He argues that "mortality deceleration" is no more than a misreading of statistics. Olshansky says death rates naturally climb as a population's weaker members begin to die off, and then slow down again when only the stronger specimens remain.

The Social Security Administration (SSA) is betting that Olshansky is right, not Vaupel. But that could turn out to be a big mistake, according to Ronald D. Lee, a demographer at the University of California–Berkeley. Lee thinks SSA's estimate of the payroll tax hike it will need to keep the trust fund actuarially sound is more than 30 percent below what it ought to be. Harry Ballantyne, SSA's chief actuary, argues that Lee is incorrect. Forty-one experts convened by the Society of Actuaries have found SSA's forecast "well within the range considered reasonable," Ballantyne says.

CYBERMEDICINE

Online Prescribing Puts Patients at Risk

Calling on state medical societies, government regulators, and licensing boards, the American Medical Association (AMA) has urged action against doctors who prescribe pills online without first examining the patient. "It's inappropriate and it puts patients at great risk," said AMA trustee Donald J. Palmisano, MD, in the *American Medical News*.



According to a report by the AMA board of trustees, popular online prescriptions include Viagra, Propecia, Proscar, and Claritin. Web sites offer these and other drugs for the cost of the drug plus "consultation fees" that range from $35 to $85. The purchaser typically acknowledges a liability waiver and completes a questionnaire. Drugs can then be prescribed, paid for by charge card, and sent overnight to the patient with little medical assessment or follow-up. Moreover, patient questionnaires are open to error, and a consumer may lie to get a drug.

Doctors in Illinois, Washington, and Wisconsin have been accused of prescribing over the Internet without patient examination. Internet prescribing is being investigated by licensing boards in at least 10 other states. Palmisano, noting that no state laws currently address online prescribing, said that local medical boards need to take action against physicians prescribing drugs for patients they do not know. The AMA will assist the Federation of State Medical Boards to develop necessary laws.

However, while the AMA's report condemns inappropriate online prescribing, it does recognize legitimate uses of the Internet by physicians. "Care must be taken to protect and even enhance legitimate electronic prescribing and dispensing practices." The report sanctions online prescribing, order refills, and electronic consultations in cases where the physician and the patient have an ongoing relationship and the patient's health history is already part of the medical record.

In an effort to control online prescribing, the AMA is working with the National Association of Boards of Pharmacy to develop a voluntary seal of approval program for Internet pharmacy sites signifying that they are appropriately licensed and run.