

GOVERNMENT AFFAIRS WEEKLY

A Report to the Board of Directors

January 26, 2007

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1. TAX CUTS TO EXPAND HEALTH CARE COVERAGE

President Bush in his State of the Union address on Tuesday, January 23, promoted his proposal to offer a federal tax deduction of \$7,500 for individuals and \$15,000 for families who obtain health insurance on their own or through an employer, saying that a change in the tax code is a "necessary step to making health care affordable for more Americans." The deduction would be available to all individuals and families who purchase health insurance, regardless of the value of their policies or whether they itemize deductions on their tax returns. The proposal would pose no net cost to the government over 10 years, according to the administration. The President said that a family of four with an annual income of \$60,000 that purchases its own health insurance would save \$4,500 in taxes annually under the proposal.

Potential Tax Impact

According to the administration, about 100 million of an estimated 175 million U.S. residents with employer-sponsored health insurance initially would owe less in federal taxes under the proposal. The average employer-sponsored health plan costs about \$11,500 for families and \$4,200 for individuals in 2006. U.S. residents with the highest 20 percent of annual incomes – beginning around \$75,000 – would pay more in federal taxes under the proposal. However, 53 percent of uninsured U.S. residents pay no federal income taxes and therefore would not receive tax benefits under the proposal.

Other Health Care Issues

The President identified rising spending on entitlement programs such as Medicare and Social Security as a problem that needs to be addressed, but he did not offer any new long-term proposals to do so. He listed other ways to help improve the health care system, including expanding health savings accounts and authorizing association health plans. AS he has in the pasts, the President also called for better information technology in health care, which he said would reduce costs and medical errors. He added, "We will encourage price transparency, and to protect good doctors from junk lawsuits, we need to pass medical liability reform."

Democrats' Response

House Ways and Means Health Subcommittee Chair, Rep. Pete Stark (D-CA) said the panel would not hold hearings on the administration's tax deduction proposal, adding that it would "make a bad problem worse." Senate Majority Leader Harry Reid (D-NV)

said, "It's difficult to imagine a proposal like this making it through the House or the Senate." However, Senate Finance Committee Chair Max Baucus (D-MT) said, "It's putting health care on the table, it's a higher profile and all that's very good."

2. SEVERAL LAWMAKERS ASK FOR INCREASES IN HEALTH PROFESSIONS

Four Democratic Members of the Labor-HHS-Education Appropriations Subcommittee wrote to the Chair of the Appropriations Committee, Rep. David Obey (D-WI), to urge that the final spending bill for fiscal year 2007 include \$300 million for the Title VII health professions training programs.

As the Administration finalized the fiscal year 2008 budget request, 45 House Members wrote to President Bush calling for \$172 million for four Title VII health professions training programs including primary care medicine and dentistry.

In spite of broad Congressional support for Title VII, it appears unlikely that the final FY07 spending bill will restore the Primary Care Medicine and Dentistry Cluster to the FY05 level.

3. MEDPAC'S REPORT ON PHYSICIAN PAYMENT

The January meeting of the Medicare Payment Advisory Commission (MedPAC) included a discussion of the congressionally mandated report on alternatives to the Medicare Physician Payment formula based on the Sustainable Growth Rate (SGR).

Chairman Glenn Hackbarth summarized the commission's deliberations by saying there is broad agreement on MedPAC that the current SGR formula does not create incentives to improve care or efficiency. In fact, it has created perverse incentives to increase utilization as physicians try to keep their practices solvent.

There is no agreement on whether replacing the SGR with various types of specific expenditure targets would really work. Some commissioners said that it has been easier for physicians to lobby Congress for relief from the SGR than it has been to improve care or efficiency.

Possible Pathways for Changing the Payment System

MedPAC staff proposed two alternative approaches to fixing the Medicare payment formula that the commissioners considered.

Pathway #1

- Repeal (not replace) the SGR
- Develop and adopt new approaches for improving value, e.g.,
 - link payment to quality (e.g., P4P);
 - encourage care coordination

Pathway #2 (Phased Approach)

- New system of expenditure targets for all Medicare
- Geographic structure
- Options for sharing gains (savings) from improved efficiency
- Develop and adopt new approaches for improving value
- Maintain pressure for continual improvement
- Expand to encompass all providers (not just physicians)
- Apply on a geographic basis and permit alternative organizational approaches

- Increase the accuracy of payments (e.g., improve work relative values)
- Reward efficiency, quality and coordination across sites of care (e.g., P4P)

A vote was not taken on this chapter since the Chair felt that more detailed information on consequences under various alternatives was needed. Consequently, the report will describe alternatives to the SGR and note that fiscal reform is urgently imperative.

Quality Improvement

The report also will call for more resources for CMS in preparation for payment reform. MedPAC recognizes the quality demonstrations and pilot projects underway can improve the accuracy of existing payment systems. However, the report will argue that the rate of improvement must accelerate significantly. This was the last scheduled MedPAC meeting before the report is released March 1, 2007.

4. LEGISLATURES MAY SUPPORT PRIMARY CARE MODEL FOR MEDICAID

Many state legislatures—including Alabama, Colorado, Georgia, Hawaii, Louisiana, Mississippi, Missouri, New York, Pennsylvania, Washington, West Virginia and Wisconsin—are refocusing their Medicaid programs, or making plans to do so, on primary care. While the term “medical home” arises frequently in this refocusing effort, few have a clear and consistent definition of what the medical home constitutes. States’ plans for using a medical home model are widely divergent, illustrating the need for education of state legislators about the AAFP’s view of the medical home.

State Legislators Look to AAFP and the Chapters

The AAFP is supporting two chapters in their efforts to address Medicaid reform by utilizing the consultants serving as the Academy’s Medicaid center of expertise. With the help of the respective chapters, West Virginia and Colorado are incorporating the concepts of Community Care of North Carolina as reported in the CCNC case study delivered to chapters last year. In addition, at the request of the Wisconsin Academy, Wisconsin legislators have discussed the model with AAFP’s consultants.