

January 25, 2008

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1. ACADEMY MEMBER TESTIFIES BEFORE HOUSE SMALL BUSINESS COMMITTEE

Stephen Eby, MD, FAAFP from Cincinnati, Ohio, was the only physician who testified before the House Small Business Committee on January 23 on the topic of the challenges facing small businesses in providing health insurance benefits for their employees. He was joined on the panel by a family farmer, a florist, a certified public accountant, a home builder and a daycare operator. Each witness described the difficulties experienced in providing health insurance for employees and their dependants.

Dr. Eby testified that his practice has never been able to afford health insurance for family members of their employees. He related specific examples encountered by his six-doctor, 25 employee practice caused by an 80-percent increase in health insurance premiums between 2003 and 2008. He also pointed out that not only is it his employees who are struggling with these insurance costs. "My wife and I cannot obtain health insurance through my practice because the premiums are unaffordable. She is a registered nurse with her Master's degree, so she was able to take a second job with a large hospital system in order for us to get affordable health insurance coverage," he said.

Making the case that "affordability is a relative concept comprised of both expenses and revenues," Dr. Eby described the significant problem on the income side particularly affecting small primary care practices. "And that problem is the statutory formula for determining physician payment under Medicare. This formula, known as the sustainable growth rate (SGR) is dysfunctional and inaccurate. Due to the cumulative nature of the SGR, payment rates have not kept pace with medical inflation, even as measured by the government. Physicians are currently being paid at 2001 rates and if Congress doesn't intervene, a steep 10.6 percent cut will take effect July 1 of this year," he emphasized.

"The inability of medical doctors to offer adequate health insurance benefits to their employees, or in some cases even themselves, is more proof that a health insurance crisis exists today in this country," Dr. Eby told the committee.

During the question and answer period, Dr. Eby responded to a number of inquiries from Rep. Nydia Velazquez (D-NY), who chairs the committee, and the senior Republican, Rep. Steve Chabot (R-OH), who asked for his views on proposals for association health plans, health savings accounts, universal coverage and “socialized medicine.” Dr. Eby pointed out that while rising premiums are often explained by the increase in health care costs generally; insurance reimbursement rates for physicians have not kept pace with the staggering increases in premiums. Moreover, he pointed out that more emphasis on primary care and the adoption of a “medical home” for every patient would increase the value of the health services provided and reduce costs for payers.

2. SENATE FINANCE COMMITTEE TO CONSIDER PHYSICIAN PAYMENT BILL

Senate Democrats plan to move quickly this year on a Medicare reform bill that blocks upcoming physician payment cuts for 18 months and potentially includes modifications to the payment formula. As part of this process, the Senate Finance Committee will hold hearings spotlighting overpayments to Medicare Advantage plans to lay the groundwork for reducing them to offset the costs of the increased payments to physicians. If Congress does not act by June 30, a 10.6 percent reduction in Medicare’s payments to physicians will become effective. There has been some discussion of letting the increase go into effect but include a retroactive payment increase in the final spending bill at the end of the year

Many Republican Senators and the White House are opposed to cuts in payments to Medicare Advantage plans, even if they are used to offset a physician payment measure. The cost of extending the current payment rate for 18 months is estimated to be \$12-\$15 billion. It is difficult to see how the Finance Committee can offset the costs of the physician payment measure without reducing the costs of the Medicare Advantage plans.

Meanwhile, Michael Leavitt, Secretary of Health and Human Services, has predicted that the President’s budget will include a proposal to change the Medicare sustainable growth rate (SGR) formula, which is the basis for much of the problems with the payment system.

Another area of uncertainty is whether the Senate Finance Committee bill that will emerge from this process will include any significant assistance for health information technology (HIT). Some of the members of the committee, for example, are pressing to include a mandate for e-prescribing by 2009. The AAFP, as do most other physician groups, supports e-prescribing only when the necessary technical infrastructure is in place and provides incentives to physicians to use it.

The AAFP’s position on the physician payment issue is that Congress should pass an 18-month extension of the Medicare update, with an eye to using the time to find a permanent solution to the broken SGR. With that goal in mind, the AAFP staff have been working with other physician groups and the AMA to develop a simple 18-month extension bill that we would ask Congressional leaders to introduce and use as the basis for resolving the crisis this year. AAFP leadership will meet with Finance Committee members to urge a quick and appropriate resolution to this payment issue.

3. PRESIDENT SIGNS CATCH-ALL SPENDING BILL

On December 26, 2007, President Bush signed the final spending bill for fiscal year 2008 (HR 2764). The law provides for \$555 billion for 11 of the 12 regular spending measures, plus \$70 billion in funding for the wars in Iraq and Afghanistan. Although the omnibus bill met the spending limit set by President Bush, Congressional Democrats were able to restore a number of programs targeted for elimination by the Administration’s budget.

For FY 2008, Title VII Health Professions Training programs received \$194 million, an increase of \$10 million above FY07 and \$184 million more than the budget request. Within that account and despite a president's budget request to eliminate the program, Primary Care Medicine and Dentistry got \$47,998,000 or \$853,000 less than FY07 as a result of an across-the-board cut.

The White House must submit to the Congress the budget request for fiscal year 2009 by February 4. In a contentious election year, few in Washington expect that the appropriations bills will be enacted by the October 1 start of the next fiscal year.

4. VETO OVERRIDE OF CHILDREN'S HEALTH INSURANCE EXPANSION FAILS

On Wednesday, January 23, the House voted 260-152 to override the President's veto of legislation to expand the availability of the State Children's Health Insurance Program (SCHIP). However, this was 15 votes short of the two-thirds needed to override the veto. The measure (HR 3963) would have expanded the SCHIP program by \$35 billion over five years. The expansion would have been financed by an increase in tobacco taxes. The goal was to cover 10 million children.

5. FamMedPAC BOARD LOOKS OVER 2008 CANDIDATES FOR CONGRESS

At the FamMedPAC Board of Directors annual meeting on January 19 in Kansas City, the Board approved a new policy to govern how requests for PAC support from members of AAFP will be handled. The policy points out that, as with other non-incumbents, AAFP-member candidates must go through the normal evaluation process, including filling out the FamMedPAC Candidate Questionnaire. The policy is designed to give some special consideration to AAFP-member candidates, but requires that other factors, including viability, be examined. The full policy, as approved, will be available on the FamMedPAC website.

The Board also approved a revised contribution budget for 2008. The changes in the previously approved budget reflect the large number of retirements in the House and the changes in the membership of both the AAFP Board of Directors and the Commission on Governmental Advocacy. Funds have been earmarked so that members of both the Board and Commission can attend or host an event for their local Members of Congress in 2008.

The first phase of the PAC direct marketing program, approved by the AAFP Board of Directors in December, has begun. Letters and e-mails were sent to 6,000 non-donor AAFP members the second week of January. Initial follow-up calls began this week to sample receptiveness to the program and to fine-tune the script callers will use. Preliminary results are favorable, with several contributions received. The calling program will kick into high gear next week.

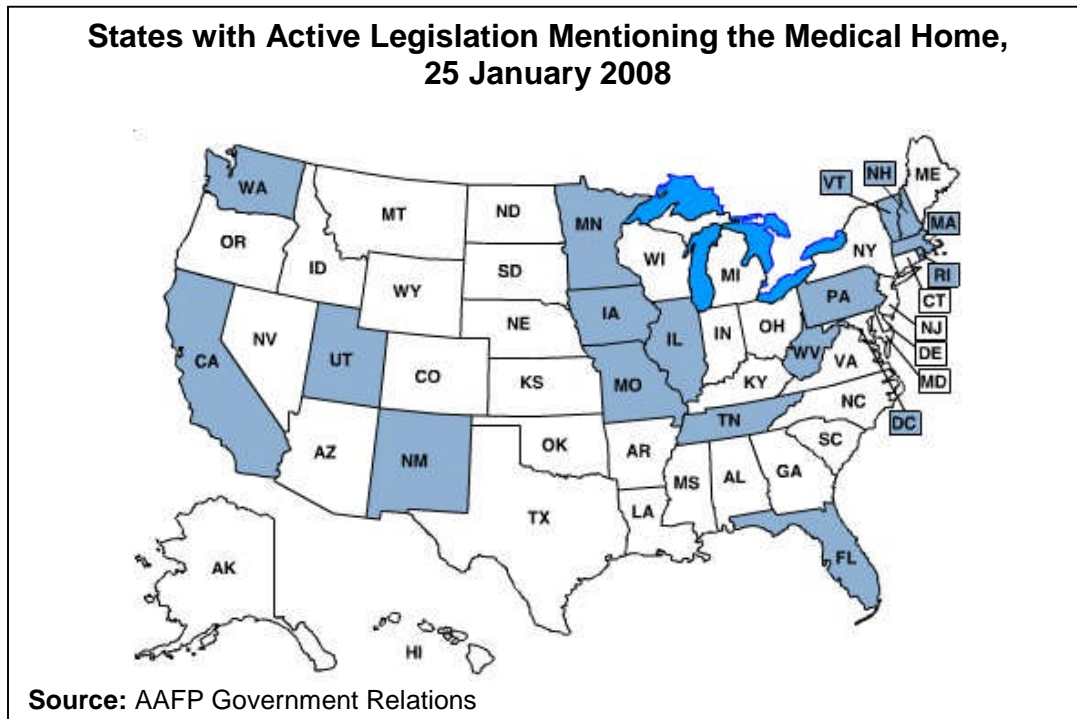
With Congress returning to Washington next week, fundraising events for the 2008 election have already been scheduled. This week, the Democratic Congressional Campaign Committee held a briefing on the key races, and the Republican Mainstreet Partnership, a coalition of the moderate Republicans in the House, held a roundtable discussion of the key issues they plan to pursue this year. FamMedPAC contributed to both groups last year and will be contributing to them again in 2008. Next week, FamMedPAC is participating in events for Delegate Donna Christensen (D-VI), a family physician, and a healthcare event for the Democratic Senatorial Campaign Committee, featuring Sen. Ted Kennedy (MA) and Sen. Sherrod Brown (OH).

The PAC Board is requesting that any AAFP member who plans to be in Washington, D.C., let the Government Relations office know. If there are fundraising events during their visit, it is possible that the member may be able to represent family medicine at the event.

The PAC has received \$42,365 in contributions since January 1, 2008. This compares to just over \$33,000 in contributions received in January of 2007. To date, 66 AAFP members have made a contribution.

5. MOST STATE LEGISLATURES BEGIN THE 2008 SESSION

# Legislatures in Session in 2008:	44 + DC
Legislatures not in Session in 2008:	AR, MT, ND, NV, OR, TX
Bills Introduced or Pre-filed So Far:	117,721
Bill Mentioning "Medical Home":	55 bills in 17 states
Regulatory Changes:	132 notices in 21 states



- **MARYLAND STUDY FORECASTS GROWING PHYSICIAN SHORTAGE**
Maryland has a growing shortage of physicians, especially medical specialists, that threatens patient access to care, according to a new [study](#) by the Maryland Hospital Association and Maryland State Medical Society. Overall, the state has 16 percent fewer physicians in clinical practice than the national average, with the greatest shortages in rural areas, the study found. One reason for the shortages is an aging physician workforce; one-third of the state's clinical physicians are 55 or older. Among other remedies, the study calls for the Governor's Task Force on Health Care Access and Reimbursement to recommend higher physician reimbursement rates and for a state loan forgiveness program to draw young physicians to regions most in need. Statewide, the largest shortages are in primary care, emergency medicine, anesthesiology, hematology/oncology, thoracic and vascular surgery, psychiatry and dermatology. The study also projects future shortages in nearly all pediatric specialties and diagnostic radiology.

- **IOWA COMMISSION RECOMMENDS INSURING ALL CHILDREN**

The Iowa Legislative Commission on Affordable Health Care on Tuesday recommended that lawmakers extend health coverage to all children in the state as the first step to establishing universal coverage. The commission—composed of legislators, health care providers, representatives of the insurance industry and small businesses—recommended that the state cover the estimated 25,000 to 30,000 children who qualify for [Hawk-I](#), the state's version of SCHIP, but are not enrolled. Commission Co-Chair and state Rep. Ro Foege (D) said, "Our first step and our top recommendation for the upcoming legislative session is to make sure that all Iowa kids have health insurance." According to Co-Chair and state Rep. Jack Hatch (D), enrolling eligible children would cost the state \$20 million, assuming \$30 million in federal matching funds.

The commission also recommended that the Legislature determine the cost of universal health care and identify potential funding sources. Other recommendations include the development of "medical homes" for all residents, which would allow coordinated care to be provided at lower costs; the expanded use of electronic health records; and incentives for employers to offer wellness programs and health insurance to employees. Hatch said that he and Foege intend to provide more specific proposals in legislation they are drafting.

- **NEW YORK PROPOSES HEALTH CARE EMPHASIZING PRIMARY CARE**

Instead of waiting for hours in an emergency room or landing in a nursing home, New Yorkers with government health coverage will soon have opportunity to avoid those costly treatment venues by going to their own family doctor.

In his State of the State address Wednesday, Gov. Eliot Spitzer (D) proposed changing the way New York reimburses hospitals and doctors for services—part of overall changes aimed at making health care cheaper for taxpayers and better for patients.

The current system for reimbursing doctors in the pay-per-visit Medicaid and Family Health Plus programs hasn't been updated since 1981, said Dr. Richard Daines, the state health commissioner. When primary care doctors are paid a fee that reflects the service they deliver, patients will have more options, he said.

"If we are able to pay higher rates to primary care doctors, it will be easier to find a family doctor," Daines said.

- **OKLAHOMA LEGISLATION SUPPORTS MEDICAL HOME**

The Oklahoma AFP is working with Sen. Connie Johnson (D) on a resolution of support for the Patient-Centered Medical Home (PCMH) to be introduced in both Houses on February 20, 2008 – Medicine Day at the Oklahoma Capitol. Sen. Johnson carried the PCMH resolution at the Council of State Governments and is also interested in introducing a similar resolution at the National Caucus of Black State Legislators.