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1. MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS SCRUTINIZED

Senator Max Baucus (D-MT), who chairs the Senate Finance Committee, conducted a hearing on Wednesday, January 30 that explored the complaints associated with private fee-for-service plans that are part of Medicare Advantage health plans. The plans have been criticized for being overpaid, not offering any additional benefits and not delivering quality care. Despite this, there is evidence that in some cases they pay physicians less than traditional Medicare fee-for-service. In addition, their sales and marketing tactics have been questioned.

The committee heard from Dr. Albert Fisk, medical director at the Everett Clinic in Washington state, who said his clinic's "abysmal" experiences with private fee-for-service plans have led facility officials to announce that as of January 2009, they will not accept any of those plans' patients. The insurers, he said, "are extremely hard to deal with both in terms of negotiating fair rates and collaboration on care coordination. We have been very frustrated with both identifying the private fee-for-service plans and negotiating fair funding."

Mark Miller, Ph.D., executive director of MedPAC, testified that the PFFS plans are symptomatic of the problems with Medicare managed care in general. The federal government pays Medicare managed care 13 percent more, and PFFS plans about 17 percent more, than traditional Medicare plans, creating a "current payment mechanism that is flawed" and one that "invites inefficient plans to join Medicare," said Miller. MedPAC has recommended that all Medicare plans be paid the same as traditional fee-for-service providers.

Elyse Politi, state health insurance program coordinator for the New River Valley on Aging, which provides services to seniors in southwestern Virginia, said private fee-for-service plans were convincing beneficiaries to enroll in their plans by telling them there would be no premiums for medications, and that they would not have to pay premiums for their health insurance other than Medicare Part B costs. However, Politi reported that the insurance representatives failed to tell beneficiaries about other out-of-pocket deductibles and co-pays that resulted in dramatic cost increases.

Additional witnesses stated that private fee-for-service plans, which are not subject to the same federal regulations as other Medicare Advantage plans, are not required to have networks of providers, and do not have to submit data about the quality of care their enrollees receive. Except for the Committee's senior Republican member, Senator Charles Grassley (R-IA), only Democratic senators participated in the hearing. They agreed with the witnesses that the plans cover fewer medical services and pay hospitals, physicians and other providers at lower rates and cost the Medicare program more than traditional fee-for-service.

Administration officials have staunchly opposed reductions in Medicare Advantage funding, which Congressional Democrats have tried to use as offsets to increase in Medicare physician payments. Enrollment in the fee-for-service plans, which were created in 1997, exploded after the Medicare prescription drug benefit was enacted in 2003, since it increased payment rates for private plans in Medicare. According to MedPAC, enrollment in the private fee-for-service plans has increased eightfold in just two years, to a total of 1.7 million.

2. SENATE BUDGET COMMITTEE EXAMINES HEALTH CARE COST GROWTH

Congressional Budget Office (CBO) Director Peter Orszag testified at the Senate Budget Committee Thursday on the growth in health care costs. At the hearing, Senator Kent Conrad (D-ND), who chairs the committee, called for health care reforms to eliminate the geographic variance in spending which does not demonstrate better care in more costly regions; to promote adoption of e-prescribing and electronic medical records; to coordinate care for the chronically ill; and to encourage preventive care and healthy lifestyles.

The senior Republican on the committee, Senator Judd Gregg (R-NH), touted the *Medicare Quality Enhancement Act*, the bill he and Sen. Hillary Clinton (D-NY) introduced to make Medicare data more widely available. He called for Medicare part D premiums based on income. Senators Conrad and Gregg also support establishing a bipartisan task force on health care reform.

Senator Michael Enzi (R-WY), citing the political need for breaking health care reform into manageable pieces, indicated that the first step was health information technology (HIT). He complained that the Congressional Budget Office (CBO) has estimated that it would cost \$317 million to implement effective HIT nationally, even though Rand has projected savings from HIT. Peter Orszag, Ph. D., who directs CBO, said that installing HIT in an integrated system would be helpful, but that no cost savings would be realized in our current fragmented, decentralized system.

Dr. Orszag's testimony coincided with the release of the CBO study *Technological Change and the Growth of Health Care Spending* (<http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf>). He told the Committee that over the past four decades, per capita health spending grew much more rapidly than per capita GDP. CBO has projected that total spending on health care will rise from 16 percent of GDP in 2007 to 25 percent in 2025 and 49 percent in 2082. Federal spending on Medicare and Medicaid would rise from 4 percent of GDP in 2007 to 7 percent in 2025 and 19 percent in 2082.

Orszag pointed to a consensus among health economists that growth in spending on health care was principally the result of the emergence of new medical technologies and services and their widespread adoption by the health care system. Other factors that have contributed to health care spending increases include the aging of the population, the growth in personal income and the rising share of health care costs paid by third-party insurers. He stated that since medical care is a desired service, people purchase more of it as their income increases.

Notably, he said that physician-induced demand and defensive medicine were not found to explain a significant part of the growth in health care spending.

3. ECONOMIC STIMULUS LACKS HEALTH CARE COMPONENT

The President and leaders of the House agreed on legislation (H.R. 5140) designed to stimulate a slowing national economy. The bill, which the House approved on Wednesday, January 30, by a vote of 385-35, includes tax rebates and small business incentives totaling \$145 billion. It does not include, however, a proposal from House and Senate Democrats to increase temporarily Medicaid's federal matching rates for states. The AAFP signed a letter that called on Congress to include such an increase because Medicaid is a "targeted and effective stimulus tool" that is particularly important during economic downturns. The Senate Finance Committee did not include a Medicaid increase in its version of this bill, but it may be debated by the full Senate next week.

To see the letter that AAFP signed:

http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/endorse-letters/econstimulusleg.Par.0001.File.tmp/FMAP%20Letter%20to%20Congress%20Final.pdf

4. SENATORS WANT TO EXPAND MEDICARE QUALITY REPORTING

Senators Max Baucus (D-MT) and Charles Grassley (R-IA) have asked CMS to work with Congress to expand the Medicare physician bonus program beyond the current focus on reporting quality data. They said that they intend to introduce legislation that would extend incentive payments for 2009 and future years and provide additional authority allowing the posting of the names of clinicians and group practices that participate satisfactorily.

5. FamMedPAC BEGINS DIRECT MARKETING TO MEMBERS

Calls to AAFP members on behalf of the PAC began this week. The calls are a follow up to the initial fundraising mailing and e-mail to 6,000 non-PAC donor AAFP members that went out last week. This first week of calling is testing the effectiveness of the initial mailing and the script used by the callers. Initial results are very favorable, with 14.5 percent of members contacted by phone making a contribution. Members have made almost \$15,000 in pledges to the PAC.

Washington staff participated in a fundraising event this week for Delegate Donna Christensen (D-VI), a family physician. Del. Christensen pledged to speak with Energy and Commerce Committee Chairman John Dingell about the Medicare physician payment formula and asked for position papers on the medical home. Staff also attended a healthcare briefing sponsored by the Democratic Senatorial Campaign Committee, featuring Sen. Ted Kennedy (MA) and Sen. Sherrod Brown (OH). Both spoke of the need to find a way to halt the cuts in the Medicare fee schedule. Both also felt that the current Congress would not tackle healthcare reform issues this year, but expressed optimism that major healthcare reform would be taken up by the next Congress in 2009.

The PAC has received \$48,940 in contributions since January 1, 2008.

6. PRESIDENT WILL PROPOSE BIG REDUCTIONS IN FEDERAL HEALTH PROGRAMS

On February 4, President Bush will propose slashing discretionary spending for health programs by more than \$2 billion, according to early reports on his final budget. In it, the Health Resources and Services Administration (HRSA), which manages many of the federal public

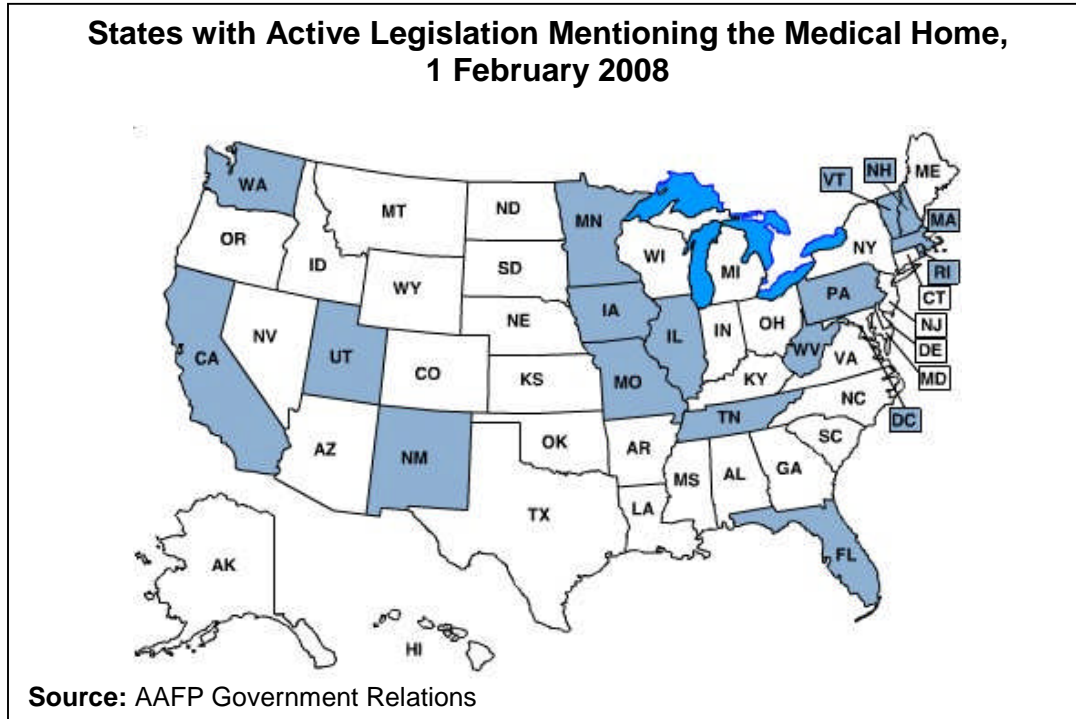
health programs, including the Health Professions Grants that go to departments of family medicine and some residency programs, will see a reduction of about \$1.1 billion over last year's levels. In addition to the reductions in discretionary spending, the Administration will propose separately reducing spending in Medicare by about \$178 billion over five years. While the Democratic Congress is not likely to accept reductions of this magnitude in the Congressional budget, the administration will use the President's budget as a guideline for determining which spending bills to veto. Thus, the President's budget proposal is likely to initiate contentious and prolonged budget confrontations.

7. IOM CALLS FOR NATIONAL BODY TO EVALUATE HEALTH TREATMENTS

The Institute of Medicine has issued a report recommending the creation of a national program to assess the effectiveness of clinical services and to provide unbiased information about what works in health care. The IOM said that solving some of the most pressing health problems depends on the ability to identify which diagnostic, treatment and prevention services work best for various patients and circumstances. The report recommends that Congress direct Health and Human Services to establish a program to set priorities for evaluating clinical services and to conduct systematic reviews of the evidence. The program would be responsible for developing and promoting rigorous standards for clinical practice guidelines that could help minimize the use of questionable services.

8. STATE LEGISLATURES PROMOTE MEDICAL HOME

The patient-centered medical home concept continues to intrigue state legislators, with some 55 bills introduced in 17 states and the District of Columbia so far in the 2008 legislative sessions. These bills run the gamut from simply using the term "medical home" to creating medical home demonstration projects or systems of care. AAFP staff continues to work with chapters to identify new bills as they are filed and to work towards incorporating the Joint Principles of the Patient-Centered Medical Home into such legislation.



Michigan Academy of Family Physicians presented the Patient-Centered Medical Home model as a potential solution for reform of the state's Medicaid program to legislators on January 30. The briefing successfully used AAFP's background materials on Community Care of North

Carolina (CCNC). Gaining momentum for the concept, the chapter also is meeting with the executive director of the Michigan Association of Health Plans with the goal of collaborating on potential pilot projects. The chapter has requested additional expertise for a legislative hearing on February 21, and AAFP is working with the chapter to have Steve Wilhite (AAFP consultant) provide testimony on the CCNC program.

9. CALIFORNIA SENATE HEALTH COMMITTEE SCUTTLES REFORM

The California Senate Health Committee voted 7-1 on Monday, January 28, to reject the compromise universal health care coverage bill that Governor Arnold Schwarzenegger (R) negotiated with the state Assembly. The vote effectively halts the reform effort and unravels several years' worth of tense negotiations between the governor, legislators, and many stakeholders. Senate Republicans would not support the bill, requiring Democrats to remain unified.

However, several committee Democrats signaled their concerns over the bill's treatment of low-income Californians and the availability of funding for the program. Critics believe if the proposal falls apart financially in a few years, it would force the state to cancel new healthcare services or increase taxes by billions of dollars. In addition, they claim the measure is too financially risky with the state facing a \$14.5-billion budget gap that could force substantial cuts to healthcare programs that already exist. Gov. Schwarzenegger already has proposed \$2.9 billion in healthcare cuts over the next 18 months.