CMS Projects 9.9% Medicare Fee Cut for 2008

BY MARY ELLEN SCHNEIDER
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Physicians will face a nearly 10% cut in Medicare payments in 2008 if Congress does not act to reverse it in the next few months.

Officials at the Centers for Medicare and Medicaid Services published a proposed rule outlining the projected 9.9% payment cut and other policy changes under the Medicare Physician Fee Schedule in the July 12 Federal Register; the agency was accept ing comments until Aug. 31. The final fee schedule rule will be published later this year.

The proposed rule also addresses the continuance of PQRI, and CMS officials are considering accepting clinical data from electronic health records.

A 9.9% cut would have devastating consequences for physicians and patients alike but is unlikely to be carried out, physicians said in interviews. Instead, Congress is likely to follow the pattern of the last 5 years and provide a 1- or 2-year temporary reprieve.

By law, CMS officials must adjust physician payments according to the sustainable growth rate (SGR) formula, which calculates physician payments based in part on the gross domestic product. The major medical specialty societies have been lobbying for years to change the formula, which they say does not account for their rising practice costs.

The proposed rule also addresses the continuance of the voluntary CMS' Physician Quality Reporting Initiative (PQRI) in 2008, and outlines new quality measures for next year. CMS officials are considering the feasibility of accepting clinical data from electronic health records. The agency will weigh whether to accept data on a limited number of ambulatory care PQRI measures for which data may also be submitted under the current Doctors Office Quality Information Technology Project (DOQ-IT). In 2008, submission through an electronic health record would be an alternative to the current claims-based reporting of data.

The proposed rule also outlines ways the agency would like to test the use of clinical data registries to report PQRI data. The testing, which would begin in 2008, would evaluate methods for physicians to report data to clinical data registries and for the registries to submit the data on the physician's behalf to CMS.

CMS officials are proposing to fund the bonus payments for the 2008 PQRI program by using $1.35 billion provided by Congress as part of the Physician Assistance and Quality Initiative Fund. In the proposed rule, CMS stated that the bonus payments were likely to be about 1.5% of allowed Medicare charges, not to exceed 2%.

That decision was criticized by the American Medical Association, which said the $1.35 billion should be used to reduce the projected 2008 physician pay cut. CMS estimates the $1.35 billion would reduce the projected cut by about 2%.

"The AMA and 85 other physician and health professional organizations sent a letter strongly urging the Administration to use this money to help Medicare physician payments keep pace with increases in practice costs. The Medicare Payment Advisory Commission made a similar recommendation," Dr. Cecil B. Wilson, an AMA board member, said in a statement.

"CMS has chosen to spend all of the money to provide just 1.5% to 2% to physicians who report on certain quality measures."

The proposed rule made other policy changes, including revising the methodology used to determine the average sales price for Part B drugs purchased in bundling arrangements. CMS is proposing to require drug manufacturers to report price concessions proportionately to the dollar value of the units of each drug sold under the bundling arrangement. ■

Medicare Private Plans Under Pressure To Prove Themselves on Cost Control

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — If competition drives prices down, why does the government pay private insurers more per patient than the Medicare program spends on the average beneficiary?

That is the question on the minds of a growing number of people, said panelists at a press briefing on health care costs sponsored by the Center for Studying Health System Change.

"A lot of folks are suffering from amnesia about this whole issue. In 2003, we passed something called the Medicare Modernization Act.… It was about how are we going to solve the baby boomer problem, how are we going to bring Medicare costs under control," said Robert Laszewski, president of a health policy and marketplace consulting firm in Alexandria, Va.

At the time, the Republican-led Congress decided that the best way to bring costs under control was to encourage more Medicare beneficiaries to join private plans. So, depending upon which type of plan they offer, managed care companies receive 10%-20% above what Medicare spends on the average beneficiary in the government-run, fee-for-service system. This would induce private insurers to offer managed Medicare products and enable them to offer more benefits to attract beneficiaries into the private plans, according to the philosophy behind the legislation.

It's 4 years later, Democrats are in power in Congress, and some are beginning to wonder what they are buying with the millions of extra dollars flowing to private insurers. Physician thought leaders, including those on the government's Medicare Physician Advisory Commission (MedPAC), have called for Congress to redirect those funds toward other priorities, such as fixing the sustainable growth rate formula.

However, it may be too early to pull the plug on this experiment in using private insurers to control costs, said Christine Arnold, a managing director at Morgan Stanley, where she covers the managed care industry.

"The managed care companies that I speak to say that they can reduce medical costs 10% for a managed product versus an unmanaged product, but it takes 2-4 years," she said.

It is not just in the Medicare program that the cost-saving techniques of managed care companies are being questioned.

Health savings accounts and other consumer-driven approaches are beginning to lose favor with the public. The number of U.S. workers who enrolled in consumer-directed plans grew by a meager 300,000 between 2005 and 2006, according to the Kaiser Family Foundation's annual survey of employer benefits.

A survey by America's Health Insurance Plans, a trade organization, seems to confirm that trend. After a couple of years in which enrollment in health savings account–affiliated, high-deductible plans doubled and then tripled, last year the number of people in the plans grew by less than a third.

Consumer-directed plans may be a good idea, but they're based on a false assumption that patients have the resources to make the right choices, said Douglas Simpson, the senior managed care analyst at Merrill Lynch & Co.

"We're incentivizing them with the benefit structure, but then we're really not giving them the tools to make better decisions. It's sort of like giving somebody $100 to go out to dinner and then not putting the prices on the menu," Mr. Simpson said.

The cyclical nature of health care reform also is becoming more apparent, said Joshua Raskin, who covers the managed care industry as a senior vice president at Lehman Brothers Inc. During the late 1980s and early 1990s, health care premiums were growing by double digits. That resulted in a political backlash. At the time, it was Hillary Clinton's universal care plan that further popularized health maintenance organizations.

"HMOs had this huge period of proliferation, and you got the cost trending down in the mid-1990s to … really low single digits," said Mr. Raskin. Then, the economy picked back up—and so did medical cost trends—and double-digit growth returned in the late 1990s into the early 2000s. Now, he said, the discussion is again focusing on "more government intervention. It's 2007 and 2008, and guess what: Hillary Clinton is back, and so is universal health care." ■

Most Part D Plans Cover A Brand-Name Drug in Each Treatment Class

Although formularies under Medicare Part D plans vary widely, nearly all plans cover at least one brand-name drug in many commonly prescribed treatment classes, according to research published in the Journal of the American Medical Association.

The researchers, who looked at Part D plans in California, studied eight treatment classes, including angiotensin-converting enzyme inhibitors, angiotensin II receptor blockers, β-blockers, calcium channel blockers, loop diuretics, selective serotonin reuptake inhibitors, statins, and thiazide diuretics. They looked at how often drugs were included in at least 90% of formularies at copayments of $35 or less without prior authorization.

"Providers can have a difficult time knowing which drug is paid for by Medicare Part D because there are over 1,800 plans, and there's a great deal of variation among these formularies," Dr. Chien-Wen Tseng, a researcher at the University of Hawaii and the Pacific Health Research Institute, said in an interview.

But "despite the large number of plans and variation among their formularies, for most of the treatment classes we examined, we found one or more drugs that were covered by nearly 100% of Part D formularies," Dr. Tseng said.

Nearly all of these widely covered drugs are generics, according to the study, which also noted that the drugs covered by Part D formularies are likely to change over time as generics become available and as new clinical data are released (JAMA 2007;297:2596-602).

For example, simvastatin (Zocor) and sertraline (Zoloft) became available as generics in 2006. Earlier that year, 71% of formularies had covered simvastatin as a brand name, while 74% covered sertraline as a brand name. But by Dec. 8, 2006, after both drugs had generic equivalents, the study authors found that 93% of the formularies examined covered simvastatin as a generic, while 100% covered sertraline as a generic.

Dr. Tseng said that a Web site that tracks the list of these "widely covered" drugs potentially could help physicians determine which drugs are most likely to be covered and therefore more affordable for patients.

—Jane Anderson