Congressional Leaders Doubt a Permanent Fee Fix

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WASHINGTON — A permanent fix to the Medicare physician fee schedule "will be a difficult bill to pass through Congress," Mark Hayes, a majority spokesman for the Senate Finance Committee, said at a conference sponsored by AcademyHealth.

"It's an expensive proposition in the current budget climate we're in," Mr. Hayes said, voicing the concerns of other Republican staff members who participated in a discussion on the 2006 health care agenda. This year's midterm congressional election also will play a role in shaping progress on this issue, he said.

Driving the cuts in pay is the sustainable growth rate (SGR), a component of the Medicare payment formula that ties medical spending to the ups and downs of the national economy and determines the conversion factor update each year. Errors made to the formula in 1998 and 1999 led to a 5.4% decrease in physician payments in 2002 and will continue to cause decreases until the process is changed.

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In recent years, Congress has staved off additional reductions by providing small increases in pay. This year's Deficit Reduction Act provided another 1-year fix to the physician-payment issue, a "0%" update, instead of a fee increase.

"Unfortunately, under the existing formula, physicians are expected to take another 4.4% reduction in 2007," said Chuck Clapton, chief counsel for the House Energy and Commerce Committee's subcommittee on health.

"We have to make sure that beneficiaries continue to get access to physician services," Mr. Clapton said. At some point, this will require yet another short-term fix for 2007, but for the long term, "it's my chairman's [Rep. Joe Barton (R-Tex.)] vote that we take more [systematic] steps to address some of the underlying problems that led to these recurring issues."

Pay for performance should factor into this reform, Mr. Clapton said. "We should eventually move toward systems that are built on rewarding for high-quality services."

Sen. Max Baucus (D-Mont.), ranking member of the Senate Finance Committee, agreed that the issue was complex and expensive. "We certainly anticipate action on the issue this year," Carol Guthrie, an aide to the senator, said in an interview. "Sen. Baucus feels that it's vital, given our country's limited pool of health care dollars, to recognize and encourage excellent provider care with pay-for-performance measures."

Sen. Baucus will continue to work with Sen. Chuck Grassley (R-Iowa), chair of the Finance Committee, to approve the pay-for-performance legislation they wrote together, Ms. Guthrie said. "Sen. Baucus was very disappointed to see that most pay-for-performance provisions were stripped from the [Deficit Reduction Act]."

The panel also touched upon health savings accounts, with the Republican staffers supporting the approach as an affordable health care option that's already shown signs of success.

Congressional Democrats have historically criticized these plans for attracting only the young, healthy, and wealthy. This is what health care analysts call "adverse selection," Sen. Baucus said in a recent statement. "Encouraging healthier Americans to choose these accounts and high-deductible plans will make health care more expensive for those who stay behind in traditional coverage," he said. "Thus these accounts will lead to a weaker health care system, not a stronger one."

Other issues on the congressional health care agenda in 2006 include:

► **Medicaid's waiver process.** With the flexibility that the Deficit Reduction Act provided to the states, "we believe we will have a fresh look at [Medicaid's] 1115 waiver process," Mr. Hayes said. The waivers give states the authority to make broad changes in eligibility, benefits, or cost-sharing in Medicaid, providing additional elbow room to test innovative coverage options.

Although it's been a necessary element for states to manage their Medicaid programs, it's still largely operating the way it did in 1965, he said. "We're looking for more transparency, more accountability between the states and the budget neutrality requirements, and also more examination about the lessons learned about those demonstrations, to really turn that program into the demonstration program it was intended to be."

► **State Children's Health Insurance Program.** SCHIP is back on the agenda this year, because a number of states are facing shortfalls in 2007 for the program, Mr. Hayes said. "We want to make sure that health coverage for children is protected."

► **Health information technology networks.** The health care industry appears to be moving toward paperless systems, so it would be beneficial to come to some agreement on standards for an interoperable system, said Stephen J. Northrup, health policy staff director for the Senate Health, Education, Labor, and Pensions Committee. "We need legislation to move that process along."

► **Affordable coverage for small businesses.** The Senate Health, Education, Labor, and Pensions Committee is working on legislation to give small businesses newer and more affordable options to pool their resources, offering them more market value as well as relief from mandates, "onerous rating rules," and other reporting burdens, Mr. Northrup said. ■

POLICY & PRACTICE

Health Care Growth

One dollar of every $5 will be spent on health care by 2015, with spending reaching more than $4 trillion, according to a study from the National Health Statistics Group at the Centers for Medicare and Medicaid Services. Forecasters predict that national health spending growth will consistently outpace the growth in the gross domestic product (GDP) over the next 10 years, with health spending expected to consume 20% of GDP, compared with 16% today. Growth in total physician spending is expected to decline from 9% in 2004 to 7.5% in 2005, or a total of $430 billion. It's likely that physician spending will approach $850 billion by 2015. This figure is probably an underestimate, however, "since it incorporates Medicare payment cuts for physicians from 2006 through 2013. In fact, Congress has already eliminated the cut planned for 2006," according to a summary of the survey. In other findings, spending on prescription drugs is expected to reach $446 billion in 2015, up from $188 billion in 2004. Spending on hospital care is expected to reach $1.2 trillion in 2015, double the 2005 level. Implementation of the new Medicare Part D drug benefit, and the added burden of paying costs that had been absorbed by other sectors, will lead to a spike in Medicare growth of up to 25% in 2006. Over the next 10 years, Medicare spending is projected to increase from $309 billion in 2004 to $792 billion by 2015.

Deciphering Drug Coverage

In an effort to answer some of the many questions physicians have about the new Medicare Part D prescription drug benefit, Medicare has posted a new fact sheet on its Web site. The fact sheet includes links to formulary information, requests for prescription information and change forms, and a chart on Part B versus Part D drug coverage. The fact sheet describes the prescribing physician's role in coverage determination, exceptions, and appeals processes and provides an outline of the deadlines for prescription drug plans to respond to physician requests. The fact sheet is available online at www.cms.hhs.gov/MedlearnProducts/downloads/Part_D_Resource_Factsheet.pdf. Physicians can also find other resources on the Part D benefit online at www.cms.hhs.gov/center/provider.asp.

Part D: Not Perfect

The Medicare drug benefit isn't without its flaws, Republican staff acknowledged at a conference sponsored by AcademyHealth. "We want to make sure the program continues on to a successful conclusion, to get prescription drugs for people. It's a big part of our agenda," said Mark Hayes, a majority spokesman for the Senate Finance Committee. "Medicare prescription drug spending under this new benefit has already decreased by 20%," said Chuck Clapton, majority chief counsel for the House Energy and Commerce Committee's subcommittee on health. "That's not to say the new benefit has been a complete and full success. There have been some problems—some populations have had some issues in getting the prescription drugs they need. Beneficiaries haven't been able to enroll seamlessly." To clear up confusion over the drug benefit, Sen. Max Baucus (D-Mont.) in forthcoming legislation will propose standards for approval and classification of plan offerings so that "seniors can make apples-to-apples comparisons and reach informed decisions" about their prescription drugs, according to a statement from his office.

Medicare Formulary Guidance

The U.S. Pharmacopeia (USP) last month released its final model guidelines for use in developing Medicare prescription drug formularies in 2007. The model guidelines are used by the Centers for Medicare and Medicaid Services to evaluate the formularies created by private drug plans that participate in the Medicare Part D program. There are fewer unique categories and classes in the 2007 document—133, compared with 146 in 2006. In addition, the number of formulary key drug types, which are used by CMS to test the comprehensiveness of the formulary, has been increased from 118 to 141. The final model guidelines eliminate the distinction between nonsteroidal anti-inflammatory drugs and cyclooxygenase-2 inhibitors and between selective serotonin reuptake inhibitors and serotonin/norepinephrine reuptake inhibitors. The USP model guidelines are available online at www.usp.org.

Lester Crawford, Lobbyist

Former Food and Drug Administration Commissioner Lester Crawford, D.V.M., has taken a position at Policy Directions Inc., a Washington-based lobbying and consulting firm. Mr. Crawford will be senior counsel to the organization, which counts pharmaceutical manufacturers and biotechnology and food companies among its clients. By law, he will be barred from directly lobbying Congress for at least a year. Policy Directions declined to make him available for an interview. Mr. Crawford resigned abruptly from his FDA post in September, just 2 months after he was confirmed by the Senate. In the 5 years of the Bush Administration, the FDA has had a permanent commissioner for only 18 months. (Mr. Crawford served in an acting capacity for 16 months without Senate confirmation.) In early February, Sen. Chuck Grassley (R-Iowa) wrote to White House Chief of Staff Andrew Card asking that a permanent commissioner be nominated, adding that the agency was adrift without such leadership. For now, Dr. Andrew von Eschenbach is the acting commissioner, but also continues to hold his previous job as head of the National Cancer Institute.

—Jennifer Lubell