



January 2008

MEDICARE PHYSICIAN PAYMENT Patching the Formula for 18 months

RECOMMENDATION

The AAFP urges Congress to:

- Extend the current payment level to the end of 2008
- Provide an inflationary increase for 2009 based on the Medicare Economic Index (MEI)
- Extend the special provisions for physician shortage areas and rural practices,
- Fully pay for the payment changes in the current budget, and
- Use the 18 months of payment stability to work with physician groups and patient advocates to shape a formula that pays physicians appropriately (see Medicare Physician Payment Issues: Beyond the 18-month patch).

Background

Last year, the House of Representatives passed legislation to provide physicians with a 2-year payment increase of 0.5 percent in 2008 and 2009, and offered a general revamping of the payment formula to separate high-volume procedures (like imagining and some surgical procedures) from preventive care and chronic disease management. The purpose of the revisions to the formula was to make sure primary care was not bearing the burden of Congressional attempts to rein in rapidly increasing costs for health care services. The bill was expensive, however. It would cost approximately \$30 billion over 5 years to revise the formula in this way. To pay for these costs, the House bill proposed reducing subsidies to insurance companies that provide Medicare Advantage plans. The stated goal was to bring these managed care plans into parity with payments to regular Medicare fee-for-service.

In the Senate, the issue stalled over how to pay for a simple 0.5 increase for one or two years, without any long-term revisions to the formula. Several Senators on the Finance Committee refused to consider large cuts to Medicare Advantage health plans as a way to offset the budgetary costs of increasing physician payments. Toward the end of the session, negotiators nearly reached a compromise, using reductions in specific portions of the Medicare Advantage programs as offsets; however, the White House stepped in and argued that no reductions to Medicare Advantage would be acceptable. As a result,

www.aafp.org

President
James D. King, MD
Selmor, TN

Board Chair
Rick D. Kellerman, MD
Wichita, KS

Vice Speaker
Leah Raye Mabry, MD
San Antonio, TX

Directors
Brad Fedderly, MD, Fox Point, WI
Lori Helm, MD, Vass, NC
Robert Palby, MD, Savannah, GA
David W. Avery, MD, Wiering, WY
James Dearing, DO, Phoenix, AZ
Roland A. Goertz, MD, Waco, TX

Kenneth R. Berka, MD, Holland, OH
David A. Ellington, MD, Lexington, VA
Glen R. Stream, MD, Spokane, WA
Jason Marker, MD (New Physician Member), Mishawaka, IN
Tobie-Lynn Smith, MD (Resident Member), San Antonio, TX
Beth Lawson Lohrey (Student Member), Eudora, KS

President-elect
Ted Epperly, MD
Boise, ID

Speaker
Thomas J. Weida, MD
Littiz, PA

Executive Vice President
Douglas E. Henley, MD
Leawood, KS

the Senate passed (and the House reluctantly agreed to) a bare-bones compromise that increased the physician payment by 0.5 percent, but only until June 30. If Congress fails to act, the formula reverts to its previous level, which would amount to a decrease of 10.6 percent for the rest of the year.

The Year Ahead

The House of Representatives will allow the Senate to act first on physician payment. The Senate Finance Committee has begun to hold hearings on the Medicare Advantage program and will attempt to send a bill to the full Senate late in February or early March. This will be successful only if enough Republican members feel they can disagree with the Administration in recommending some cuts to the Medicare Advantage health plans.

The goal of the physician community is to have a bill that will offer an 18-month window of stable and predictable payments, during which time physician groups and patient advocates can negotiate a broader payment reform bill that will pay physicians adequately and eliminate the need for annually seeking payment stabilization measures.