

Medicare Showdown

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In a stunning rebuke of President George W. Bush, the House and Senate voted July 15 in a strong bipartisan fashion to override a veto he had issued only hours earlier, erasing a scheduled reduction of 10.6% in the fees that Medicare pays physicians. At the risk of alienating the nation's doctors, Bush had vetoed the measure because he strongly objected to the way in which it covered the costs of eliminating the fee reduction: by cutting payments to private Medicare Advantage plans that contract with the Centers for Medicare and Medicaid Services to provide coverage to Medicare beneficiaries. The House voted 383 to 41 and the Senate immediately followed with a 70-to-26 vote to overturn the veto and block the physician-fee cut that would have taken effect immediately. A total of 153 House Republicans and 21 GOP senators joined all voting Democrats to overturn the veto, which required a two-thirds majority in both chambers. By Congress's action, the bill became law without Bush's signature.

In his veto message, Bush said: "I support the primary objective of this legislation, to forestall reductions in physician payments. Yet taking choices away from seniors to pay physicians is wrong."¹ Bush also maintained that the bill was "fiscally irresponsible" and "would imperil the long-term fiscal soundness of Medicare by using short-term budget gimmicks that do not solve the problem; the result would be a steep and unrealistic payment cut for physicians — roughly 20% in 2010 — likely

leading to another expensive temporary fix."

The president emphasized that by reducing payments to Medicare Advantage plans, in which 9.6 million beneficiaries of the program (about 20% of all beneficiaries) are enrolled, the bill would reduce the plan options available to seniors, many of whom have low incomes. Bush made no mention of the issue at the heart of Democrats' primary criticism of Medicare Advantage plans, which include health maintenance organizations, preferred provider organizations, and so-called private fee-for-service plans: that their payment rates are substantially higher than the fees doctors receive under the traditional fee-for-service model. The administration has strongly supported this payment differential as a way to cement the role that private plans play in Medicare and to encourage beneficiaries to enroll in them. Most of the extra money covers the costs of additional benefits for Medicare beneficiaries, but some helps to bolster the bottom lines of private plans and thus to strengthen their position in the marketplace.

Bush's veto was a high-stakes gamble because both houses of Congress had approved the measure by veto-proof margins. On June 24, the House approved the bill by a surprisingly wide margin of 359 to 55, with 129 Republicans and every Democrat voting for it. Two weeks later, the Senate approved the same bill on a voice vote after Democrats secured 69 votes, 9 more than the 60 needed to invoke cloture,

whereby debate is ended and an immediate vote is taken on the matter at hand. Days before, a similar motion had garnered only 58 votes. Senator John McCain (R-AZ) was the only senator to miss both votes. Some observers attributed the change of heart among some senators to a surprise appearance by Democrat Edward M. Kennedy of Massachusetts, who returned to a standing ovation in the Senate after a long absence for treatment of a brain tumor. "Win, lose, or draw, I wanted to be here," remarked Kennedy.

Bush's veto represented yet another move in an ongoing ideological struggle over the design of Medicare that has pitted the administration against Democrats since 2001. This philosophical conflict resurfaced because Democrats pressed their case that Medicare should reduce its payments to Medicare Advantage plans, which cost the program considerably more every year than it would spend for a similar group of patients to be treated under the traditional model, according to separate analyses by the Congressional Budget Office (CBO),² the Government Accountability Office,³ and the Medicare Payment Advisory Commission (MedPAC).⁴

In 2006, Medicare paid \$59 billion to these plans — an estimated \$7.1 billion more than it would have paid if the care had been delivered under fee for service.³ Unless Medicare policy is changed in some fashion, the CBO estimates that the program's expenditures will be \$54 billion higher during the period from 2009 through 2012

Payments, Bids, and Benchmarks for Medicare Advantage Plans Relative to Fee-for-Service Expenditures, According to Plan Type, 2008.*					
Plans	Enrollment, November 2007	Payments Relative to Fee-for-Service Expenditures		Bids Relative to Fee-for-Service Expenditures, 2008	Benchmarks Relative to Fee-for-Service Expenditures, 2008
		2006	2008		
	<i>millions</i>			<i>percent</i>	
All Medicare Advantage plans with bids					
Including Puerto Rico	8.0	112	113	101	118
Excluding Puerto Rico	7.6	111	112	100	116
Plan type					
HMO	5.9	110	112	99	117
Local PPO	0.4	117	119	108	122
Regional PPO	0.2	110	112	103	115
Private fee-for-service	1.4	119	117	108	120
Special-needs plans					
Including Puerto Rico	1.0	118	115	97	121
Excluding Puerto Rico	0.8	111	109	94	114
Beneficiary eligibility					
All in service areas	6.7	112	113	99	118
Employer groups only	1.3	114	116	108	118

* Enrollment includes only plans that submitted a bid for 2008 and had the same plan identification number in 2007. Benchmarks are the maximum Medicare-program payments for Medicare Advantage plans. Data are from a Medicare Payment Advisory Commission analysis of information from the Centers for Medicare and Medicaid Services on plan bids, enrollment, benchmarks, and fee-for-service expenditures. HMO denotes health maintenance organization, and PPO preferred provider organization.

than they would be without Medicare Advantage.² In a recent report, MedPAC argued in favor of “financial neutrality” between payment rates for fee-for-service Medicare plans and Medicare Advantage programs — meaning “that the Medicare program should pay the same amount . . . regardless of which Medicare option a beneficiary chooses.” The commission had previously shown that in 2006, per-beneficiary Medicare payments to Medicare Advantage plans amounted to 112% of per-beneficiary spending in the traditional fee-for-service program, and its 2008 analysis projected an increase to 113% (see table). This means

that “the Medicare program is paying about \$10 billion more [annually] for the 20% of beneficiaries enrolled in [Medicare Advantage] plans than if they remained in [fee-for-service] Medicare,” the MedPAC report concluded.⁴

Ironically, when Congress first authorized Medicare to contract with private health plans nearly 25 years ago, its rationale was that such plans would introduce innovation into the program while saving it money.⁵ Virtually all the plans that signed on initially were not-for-profit health maintenance organizations, such as the Kaiser Permanente Medical Care Program and the Harvard Community

Health Plan. As MedPAC has noted, “Payment policy is a powerful signal of what we value. The original conception (in the 1980s) for private plans would be a mechanism for introducing innovation into the program while saving money for Medicare (they were paid 95% of [fee-for-service amounts]). By increasing payment to levels significantly above Medicare, we have changed the signal we are sending to the market: instead of efficiency-enhancing innovation, we are getting plans . . . that are much like traditional Medicare, except at a higher cost.”⁴

Enactment of the legislation

was a significant victory for the American Medical Association (AMA) and its allies. Besides blocking the 2008 physician-fee cut, the law also eliminates another scheduled fee reduction of 5.4% in 2009 and authorizes instead a 1.1% increase for next year. Through paid advertisements in the home states of Republican senators who voted against the bill the first time, the AMA applied intense pressure on these legislators to switch sides. Of the Republican senators who initially opposed the measure, nine (most of whom face reelection in 2008) switched their votes, including Lamar Alexander of Tennessee (who ranks second in the Senate Republican leadership), Saxby Chambliss of Georgia, Bob Corker of Tennessee, John Cornyn of Texas, Kay Bailey Hutchison of Texas, Johnny Isakson of Georgia, Mel Martinez of Florida, Arlen Specter of Pennsylvania, and John Warner of Virginia.

Cornyn's original no vote so upset the Texas Medical Association that the group's political action arm withdrew its endorsement of his bid for reelection. In a letter to Cornyn, Dr. Manuel Acosta, chairman of the association's political action committee, said his group was "outraged that you made the decision to follow the direction of the Bush administration and voted

to protect health insurance companies at the expense of America's seniors, those with disabilities, and military families."

Although the question of Medicare's physician fees garnered the most media attention, the new law includes a wide variety of other provisions, which made it the most heavily lobbied health measure of this session of Congress. Of particular significance to physicians, the measure grants bonuses of 0.5 to 2.0% to doctors who order prescriptions electronically between 2009 and 2013. Physicians who participate in Medicare but are not e-prescribing by 2012 will have their Medicare fees reduced by 2%. The law also offers additional incentives to primary care physicians to practice in underserved areas and establishes a physician-feedback program in which Medicare will use its claims data to provide confidential reports to doctors on the resources they use to care for Medicare beneficiaries.

Although the temporary fix for physician fees will alleviate the immediate concerns of many doctors, the remuneration problem remains unresolved for the longer term. No one is satisfied with the current formula by which Medicare calculates physician fees, but Congress has hesitated to act because of the hefty price tag that would be at-

tached to any change deemed acceptable to both policymakers and physicians. Members of Congress have urged physician groups to develop their own proposals, but because any viable plan is certain to result in both winners and losers, organized medicine, too, has been reluctant to act. So for the time being, annual Band-Aids will continue to be the standard of care for Medicare's physician-payment woes.

This article (10.1056/NEJMp0805760) was published at www.nejm.org on July 16, 2008.

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