AMA Advocacy on the CHAMP Act (H.R. 3162)

BACKGROUND

The AMA supported House passage of H.R. 3162 (the CHAMP Act) after weighing several positive elements as well as some significant areas of concern. The CHAMP Act advanced two high priority AMA issues—increasing coverage for the uninsured through the SCHIP reauthorization and replacing looming Medicare physician payment cuts with positive updates. Advancing Medicare legislation earlier in the year also represents an important tactical advantage. We are seeking to avoid recent experiences when Congress delays action to avert Medicare physician payment cuts until the final days of the session—leaving little opportunity to improve on a take-it-or-leave-it situation.

The AMA will aggressively utilize the House-Senate conference committee process to pursue improvements in the Medicare provisions in the package.

There is considerable speculation about the outcome of conference committee negotiations, a potential veto and the prospects for addressing Medicare issues in a separate piece of legislation. These are matters beyond our control. However, by working with other physician organizations and patient groups such as AARP, we have the ability and determination to influence the outcome so that the medical profession is better able to serve patients.

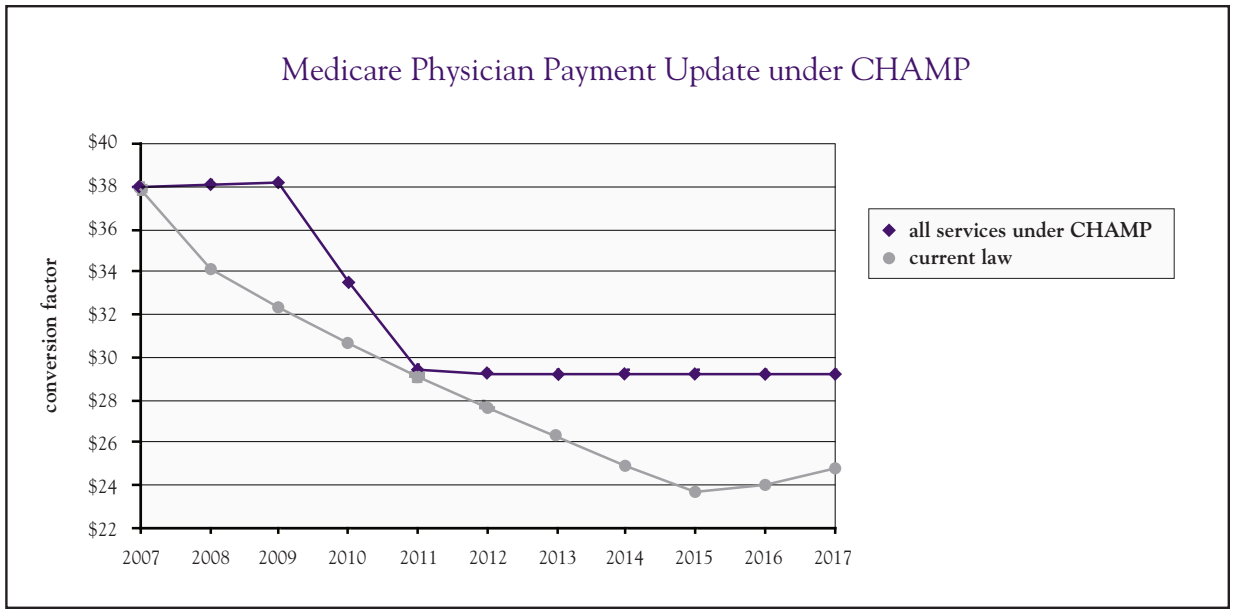
Below is a brief review of key provisions and spending estimates in the CHAMP Act.

PROS

Children's health insurance: CHAMP reauthorizes the state Children's Health Insurance Program (CHIP), continuing coverage for 6.6 million children currently enrolled and covering an additional 5.1 million uninsured children from low-income families. According to CBO, 4.6 million of these 5.1 million uninsured children have incomes below states' current eligibility limits, so the bill is targeted at low-income uninsured children. CHIP is not government-run health care: 70 percent of kids on CHIP get coverage from private plans. CHAMP maintains the current CHIP income eligibility of 200 percent of the federal poverty level; it allows states to seek waivers to increase the income eligibility levels if they meet certain criteria.

($47.4 B/5 yr; $128.7 B/10 yr)

Children's health insurance total: $47.4 B/5-yr; $128.7 B/10-yr



Medicare payment updates: CHAMP provides the largest investment that Congress has ever made to help fix the problems created by the SGR. As the chart below illustrates, the CHAMP Act spends $20 billion over five years and $67 billion over 10 years to replace 15 percent cuts in Medicare payment rates for all physician services over the next two years with positive updates of 0.5 percent.

The bill invests substantial new money to improve payments in 2008 and 2009 and also defrays a portion of the cost by moving up some pay cuts that would have occurred in the longer term, so physicians overall go from facing as many as nine years of 40 percent cuts to facing about three years of 25 percent cuts. CHAMP also removes Part B drug costs from future targets and increases the targets to account for new Medicare coverage policy decisions.

($20.2 B/5 yr; $66.9 B/10 yr)

Rural access protections: The bill extends the work GPCI floor and scarcity bonus programs that have boosted payments for millions of physicians across the country—especially in rural areas. Some physicians in rural areas face cuts up to 13 percent (17 percent in Puerto Rico) when accounting for rural payment adjusters and the SGR cuts. This provision improves payments for physicians in over half of all Medicare payment localities.

($1.7 B/5 yr; $1.7 B/10 yr)

New bonus for physicians in "efficient" areas: Physicians in the 5 percent of areas with the lowest fee-for-service (FFS) expenditures in the country would receive a 5 percent increase in their payment rates in 2009 and 2010. The additional payments were intended to improve FFS payments in a few states (Washington, Oregon and Minnesota) where congressional members were concerned about reductions in overpayments to Medicare Advantage plans. However, the provision actually will benefit physicians in more than 150 counties in 28 states.

($0.4 B/5 yr; $0.4 B/10 yr)

Expanded medical home demo: The eight-state medical home demo scheduled to begin in 2008 will be replaced and expanded with a nationwide demo of up to 500 practices beginning no later than Oct. 1, 2009.

($0.3 B/5 yr; $0.3 B/10 yr)

Physician total: $22.7 B/5-yr; $66.9 B/10-yr

Mental health co-pays: The bill would achieve a long-standing AMA goal of equalizing Medicare's copayment for outpatient mental health care with the 20 percent copayment for other physician services. Currently beneficiaries pay 50 percent of allowed charges for mental health services.

($2.2 B/5 yr; $4.7 B/10 yr)

Medicare beneficiary improvements: The CHAMP Act also expands Medicare coverage for preventive services and eliminates all copayments for these services. Programs that assist low-income beneficiaries with premiums and out-of-pocket costs would be extended to provide more targeted assistance to low-income and minority beneficiaries than they currently receive through Medicare Advantage.

($12.1 B/5 yr; $45.5 B/10 yr)

Medicare beneficiaries total: $14.3 B/5-yr; $50.2 B/10-yr

Medicare Advantage reforms: Current Medicare Advantage subsidies would be phased out over a four-year period starting in 2009. Other reforms would address marketing abuses and prohibit plans from charging higher copays than traditional Medicare for any service. **These cuts along with those to other Medicare providers made it possible to improve beneficiary protections and avert physician 2008 and 2009 pay cuts without additional premium increases.**

($50.4 B cuts/5 yr; $157.1 B cuts/10 yr)

Medicare Advantage total: $50.4 B/5-yr; $157.1 B/10-yr

CONS

Physician-owned hospitals: New physician-owned hospitals that were not already designated as Medicare providers as of July 24, 2007, would be prohibited, and physician-owned hospitals that currently have Medicare provider numbers would be prohibited from any expansion of the current number of beds. Within 18 months, these hospitals would have to have no more than 40 percent physician ownership and no more than 2 percent ownership by any individual physician. Physician-owned hospitals should not be singled out. It will be a tough battle to remove the provisions given past support by Sens. Grassley and Baucus for a physician-owned hospital ban. The AMA will continue to seek elimination of the restrictions on physician-owned hospitals.

($-0.7 B/5 yr; $-2.9 B/10 yr)

Imaging cuts and new requirements: The bill would require accreditation of diagnostic imaging service facilities. An important exception added in response to complaints from the AMA and other physician groups exempts physicians who personally furnish the imaging services they bill for. If the physician's staff furnished the technical component of the service, the equipment would need to be accredited every three years. The measure also includes several provisions that directly cut payments for imaging services, as well as other indirect cuts. Specifically, the proposed new six service-specific targets, are likely to have a more

negative impact on imaging than on other services. AMA will continue to work with affected specialties to avert further cuts to these services and address concerns regarding new accreditation requirements.

($0.4 B/5 yr; $1.2 B/10 yr)

New mis-valued procedures panel: Under the guise of "improving accuracy of relative values," the bill would set up an "expert panel" to identify potentially mis- and over-valued services to be examined by the RUC. AMA staff had ongoing discussions with congressional staff and this section was improved as a result. However, the panel's scope is largely duplicative of the work already done by the RUC and the bill still allows the Secretary to make certain types of payment cuts based only on the panel's recommendations and without input from the RUC. As further deliberations occur, we will seek to scale back the expert panel's role. **(No savings are attached to this provision.)**

High-volume services cuts: The AMA will also seek to eliminate other provisions that give the HHS Secretary authority to cut payments for high-volume and other services that the Secretary determines are mispriced or have "excessive growth"—where annual growth exceeds the average for all services by 10 or more percentage points. **(No savings are attached to these provisions.)**

Mid-level practitioner services: The bill contains several provisions that increase Medicare payments and coverage for mid-level practitioner services, including paying certified nurse-midwives 100 percent of the physician fee schedule and covering services of state-licensed or certified marriage and family therapists. The AMA will work with affected specialties to develop possible alternatives to the current provisions. MedPAC has recommended that nurse midwives be paid at 85 percent of the physician fee schedule rate and that coverage not be extended to services of the additional mental health professionals.

($0.2 B/5 yr; $0.6 B/10 yr)

OTHER

Medicare payment locality adjustment: In response to advocacy by the California Medical Association, the bill requires CMS to revise payment areas and Geographic Practice Cost Index (GPCIs) to increase payments to several California counties. No offsetting cuts in other counties would be required in 2008, 2009 and 2010, but the revisions would be made budget neutral in 2011. Furthermore, the Secretary would extend the same type of changes to 13 other states in 2011 in a budget-neutral manner, leading to significant redistributions within many states.

($0.2 B/5 yr; $0.2 B/10 yr)

HIGHLIGHTS OF CHAMP ACT SPENDING

	5 year	10 year
Children's health insurance	$ +47.4 B	$ +128.7 B
Physicians	$ +22.7 B	$ +66.9 B
Medicare beneficiaries	$ +14.3 B	$ +50.2 B
Medicare Advantage	$ -50.4 B	$ -157.1 B
Hospital, SNFs, home health	$ -9.1 B	$ -23.8 B