of the

American Medical Association

to the

Committee on Finance
United States Senate

RE: Medicare Payment for Physician Services: Examining New Approaches

Presented by: Cecil B. Wilson, MD

March 1, 2007

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Division of Legislative Counsel

Statement

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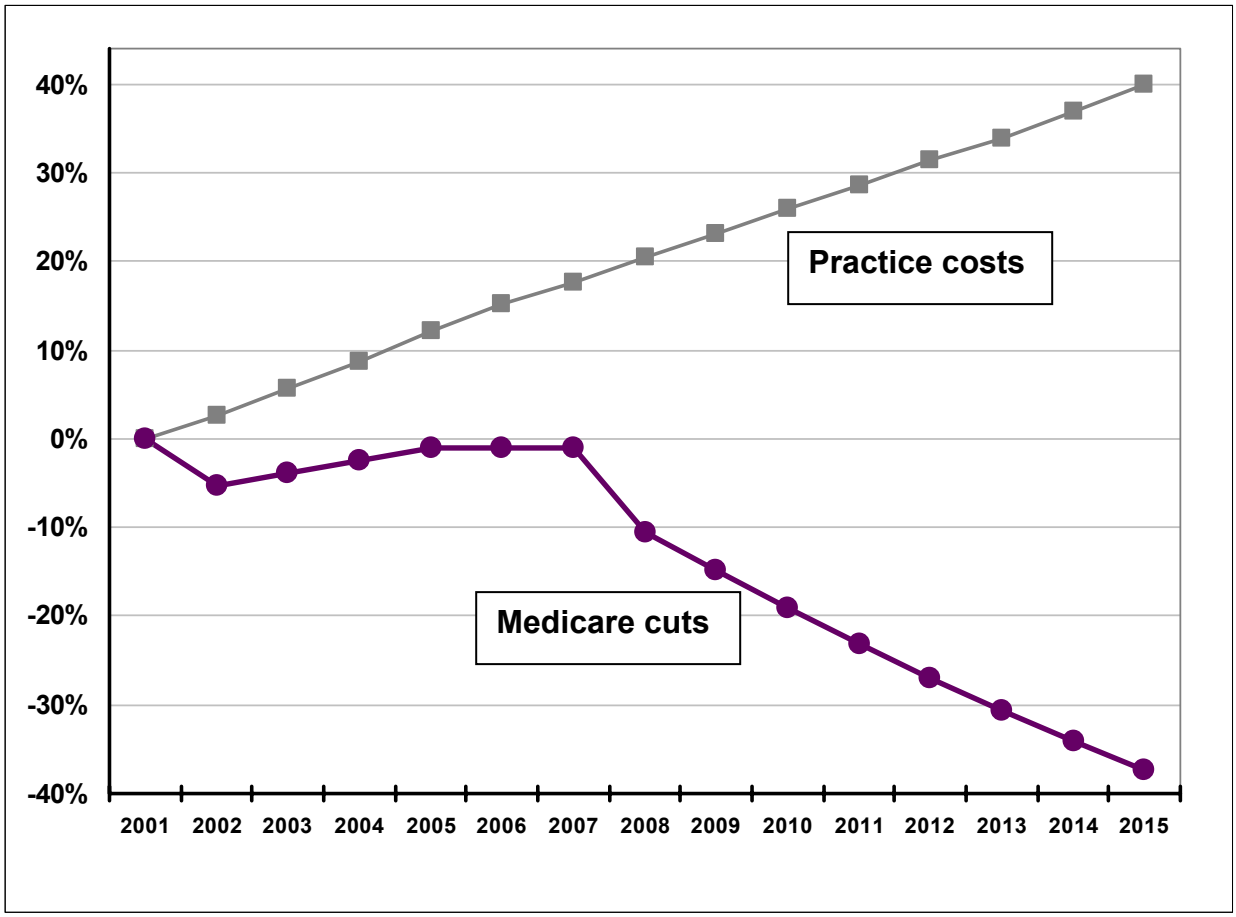
The American Medical Association (AMA) appreciates the opportunity to provide our views regarding the Medicare Payment Advisory Commission (MedPAC) Report to Congress on alternatives to the Medicare sustainable growth rate (SGR) physician payment formula. We commend you, Chairman Baucus, Senator Grassley, and Members of the Committee for all of your hard work and leadership in recognizing the fundamental need to address the fatally flawed SGR physician payment formula. It is time to find a replacement for this formula in order to ensure a firm foundation for the Medicare program both for the short- and long-term, especially as the program prepares to accept a huge influx of new enrollees as the baby boomers reach eligibility age, beginning in 2010. We are confident that working together, Congress, the Centers for Medicare and Medicaid Services (CMS), and organized medicine can achieve this goal and deliver on Medicare's long-held promise to patients — access to quality health care services furnished by the beneficiary's physician of choice.

PROJECTED PAYMENT RATES UNDER THE MEDICARE SUSTAINABLE GROWTH RATE PHYSICIAN PAYMENT FORMULA

The AMA is grateful to the Committee and Congress for taking action in each of the last five years to forestall steep Medicare physician payment cuts, due to the flawed SGR physician payment formula. We also appreciate that Congress, thanks to the efforts of the Chairman and Ranking Member of this Committee, has allocated to the Secretary of the Department of Health and Human Services under H.R. 6111, the "Tax Relief and Health Care Act of 2006," $1.35 billion to help offset the 2008 Medicare physician pay cut, and we look forward to working with CMS in the implementation of this provision. Despite these efforts, however, a Medicare meltdown still looms and it must be resolved. **Medicare payments to physicians in 2007 are essentially the same as they were in 2001, and a cut of 10% is projected for**

2008. Further, due to the SGR, physicians face drastic payment rate cuts totaling almost 40% over eight years (beginning in 2008), while physician practice costs will increase nearly 20% during that time period. These cuts come at a time when Medicare payments to physicians already lag far behind the cost of caring for seniors and just as the baby-boomers enter the Medicare program. (In 2010, the leading edge of the baby-boom generation will start enrolling in Medicare, with enrollment growing from 43 million in 2010 to 49 million by 2015.)

The chart below shows the gap in Medicare payment to physicians from 2001 through 2015, as compared to increases in medical practice costs, as measured by the government's own Medicare Economic Index (MEI).



Sources: Physician cost data is from the MEI, a conservative index of practice cost growth maintained by the Centers for Medicare & Medicaid Services. Medicare physician payment updates are from the 2006 Medicare Trustees report, with adjustments for 2008 to reflect the Congressional Budget Office analysis of the "Tax Relief and Health Care Act of 2006." Any change in pay that may result from use of the $1.35 billion "physician assistance and quality initiative fund" for 2008 is not included.

Physicians cannot absorb these draconian Medicare cuts. A 2006 AMA survey showed that that patient access will suffer as a result of the cuts. Further, a national poll conducted by the AMA shows that 82% of current Medicare patients are concerned about the cuts' impact on their access to health care. A staggering 93% of baby boomers age 45-54 are concerned about the cuts' impact on access to care.

In the long-run, all patients will have more trouble finding a physician. The Congressionally-created Council on Graduate Medical Education is already predicting a shortage of 85,000 physicians by 2020. Multi-year cuts in Medicare are nearly certain to exacerbate this shortage by making medicine a less attractive career and encouraging retirements among the 35 percent of physicians who are 55 or older.

Accordingly, we urge the Committee and Congress to work with CMS to avert future cuts by repealing the SGR and enacting a system that produces positive physician payment updates that accurately reflect increases in medical practice costs, as indicated by the MEI.

MEDICARE PAYMENT ADVISORY COMMISSION REPORT TO CONGRESS ON ALTERNATIVES TO THE SUSTAINABLE GROWTH RATE

The Deficit Reduction Act of 2005 (DRA) directed MedPAC to report to Congress, by no later than March 1, 2007, on mechanisms that could be used to replace the SGR. In large part, MedPAC's report is required to focus on methods for assessing and addressing volume growth in Medicare physicians' services while maintaining access to these services, as well as exploring whether an SGR-like target could be applied to a group practice, hospital medical staff, type of service, geographic area, as well as to outliers. In accordance with this Congressional mandate, MedPAC has issued its report to Congress, with several recommendations, as discussed below.

MedPAC Recommends A Positive Medicare Physician Payment Update For 2008 Equal To The Medicare Economic Index

In a separate March 2007 Report to Congress, MedPAC is expected to recommend that Congress establish a 1.7% Medicare physician payment update for 2008, which is intended to reflect a conservative rate of medical practice cost inflation, as measured by the MEI. **The AMA strongly supports this recommendation, and urges the Committee and Congress to avert next year's projected 10% cut and replace it with a positive 1.7% payment update, as recommended by MedPAC.** This is critical since physician payment updates have not kept up with practice cost increases for the last six years.

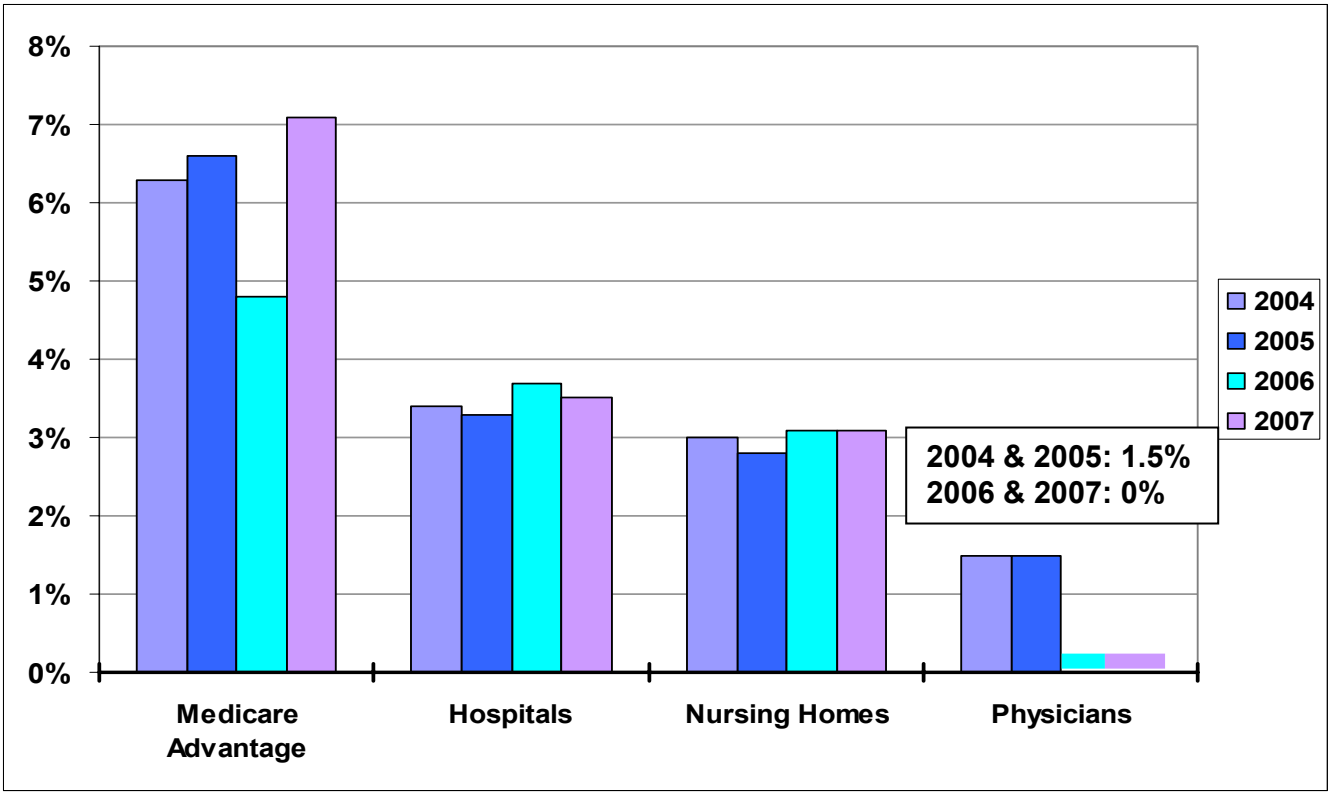
MedPAC's First Solution For The SGR: Repeal The Flawed SGR Formula

In considering a long-term approach to modernizing how Medicare pays physicians, MedPAC lays out two alternative "pathways" for Congress to consider. Under the first alternative, MedPAC reiterates its past recommendation that Congress repeal the SGR, while accelerating Medicare adoption of techniques used by private payers to control costs.

Repealing the SGR is consistent with MedPAC's long-held view that the SGR is a flawed formula for setting Medicare physician payment rates because it does not provide appropriate incentives for addressing volume growth that may be inappropriate. **Given the fatal flaws in the SGR formula and the resulting cuts that threaten the foundation of the Medicare program, the AMA strongly supports its repeal.** We believe that the SGR should be

abandoned altogether and replaced with a system that adequately reflects increases in physicians' medical practice costs. Only physicians and other health professionals (whose payment rates are tied to the physician fee schedule) face steep payment cuts. The chart below shows that physicians received below-inflation updates in 2004 and 2005, and freezes in 2006 and 2007, while other Medicare providers' payment updates have kept pace with their costs increases. Physicians and other health care professionals must have payment updates that keep pace with their cost increases, similar to the updates for other providers. Physicians are the foundation for our nation's health care system, and thus a stable payment environment for their services to maintain stable access for our nation's seniors.

Physicians vs. other providers: 2004-2007 Medicare payment updates



Source: Centers for Medicare & Medicaid Services final announcements.

Techniques To Assure Appropriate Use Of Medical Care
Are More Effective Than Spending Targets

MedPAC believes that repeal of the SGR should be predicated on adoption of mechanisms that would be put in place to address appropriate use of physicians' services. It is understandable that policymakers want some assurances that spending on these services will not increase inappropriately. The AMA believes that targeted efforts by medical professionals themselves to identify and correct inappropriate use of services would be far more effective than a spending target in constraining system-wide health care costs. We are prepared to work with Congress, the Administration, and MedPAC to explore alternatives designed to distinguish between appropriate and inappropriate services and foster prudent utilization behavior by physicians and patients. To that end, the AMA has been working with

numerous organizations representing physicians and other health professionals to identify mechanisms that would bridge current gaps in care and assure appropriate use of medical care. With these organizations, we have developed the attached document entitled "Joint Recommendations to Congress on Eliminating the SGR and Supporting Efforts to Promote Health Care Quality and Appropriateness."

These "Joint Recommendations" focus on repealing the SGR and replacing it with a system that reflects continual increases in physicians' and other health professionals' practice costs, as the first priority. Along with repeal, we jointly call on Congress to support initiatives by the profession to bridge gaps in care and assure the appropriateness of services provided to Medicare beneficiaries. Such support, as stated in the "Joint Recommendations," could include —

- Instructing HHS to work with organizations of physicians and other professionals to develop methodologies to provide accurate, confidential and comparative information to individual practitioners on how their quality and utilization compares to their peers as tools for self-improvement.
- Encouraging efforts by organizations representing physicians and other health professionals to develop voluntary guidelines on the appropriate utilization of services and to obtain and analyze data on the growth in the utilization of services and quality of services by condition, type of service, episodes of illness, region and specialty.
- Providing financial support and positive incentives to help and encourage acquisition of the tools and information technology needed to provide consistent and high quality care.
- Directing Medicare to pay medical practices for care coordination services that fall outside of a face-to-face encounter. System-wide savings—such as reductions in hospital admissions and readmissions (Part A) and more effective use of pharmacologic therapies (Part D)—achieved by these programs should be applied to funding the care coordination services. If enacted by Congress, such a policy should be considered a change in law that would not require a budget neutrality offset in the Medicare Physician Fee Schedule.
- Supporting efforts by the profession, the RUC [the AMA/Specialty Society RVS Update Committee], and CMS to improve the accuracy of Medicare's resource-based relative value scale to ensure that all costs, including uncompensated care and updated practice expenses, are recognized and that the payment system does not inadvertently encourage inappropriate treatment decisions.

The key ingredient for success in efforts to identify and prevent any inappropriate use of physicians' services is committed physicians. This is only possible under a system that seeks physician input early in the process and that is built from the ground up rather than one that imposes arbitrary targets set by federal officials and based on imperfect data.

Physicians have a solid track record for working together in addressing policymakers concerns. For example, the AMA convened the Physicians' Consortium for Performance Improvement in 2000 for the development of performance measurements. The Consortium is currently comprised of over 100 national medical specialty and state medical societies; the Council of Medical Specialty Societies; American Board of Medical Specialties and its

member-boards; experts in methodology and data collection; the Agency for Healthcare Research and Quality; and CMS. The Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance (NCQA) are also liaison members.

Through the Consortium, physicians have had exceptional success in developing physician-level performance measures and it has become the leading physician-sponsored initiative in the country. To date, the Consortium has developed 155 performance measures and 60 of the 74 measures in Medicare's Physician Quality Reporting Initiative (PQRI), came from the Consortium. The PQRI is the Medicare physician reporting program being implemented by CMS, and it will be used as the basis for physician reporting in 2007 under the reporting program established by H.R. 6111. We wish to underscore, however, that the attached "Joint Recommendations" include a call for the transitional 2007 PQRI to be re-examined before being expanded into future years to ensure, for example, that the program focuses on meaningful improvements in patient care.

The AMA emphasizes to the Committee our strong commitment to continuing the foregoing quality initiatives. We also offer our firm commitment to working with Congress, CMS, and MedPAC to develop techniques to assure the appropriateness of services, while repealing the SGR and ensuring a stable Medicare program that delivers to our seniors and disabled patients high quality, cost-effective health care services.

MedPAC's Second Alternative Solution: Expand The SGR Spending Target

Under the second alternative "pathway" for solving the SGR crisis, MedPAC outlines a plan that would move to regional spending targets that apply to all Medicare services and providers. This would be implemented on a phased-in basis, and hospital outpatient departments would be the first provider to which the target would be expanded. Newly-created organizations of hospitals and physicians called "accountable care organizations" could then receive payment bonuses if their spending growth is below the regional target.

The AMA emphasizes that MedPAC's second alternative is presented on a conceptual basis only. MedPAC has not had an opportunity to thoroughly discuss or work out the details for implementation of this type of system, and as discussed below, such implementation would run into significant obstacles. In fact, MedPAC has previously discussed expanding the SGR spending target to ambulatory care facilities, and recommended against this approach in its March 2000 report.

MedPAC essentially concluded that an expanded target was unworkable because there is no way to predict and adequately adjust for shifts in site-of service with a rigid formula, such as the SGR. MedPAC also simulated the impact of including hospital outpatient and ambulatory surgical services (ASC) in the SGR and concluded that this would "reduce the updates for all services in the expanded system" by 1% to 3%. Since hospital outpatient department spending is now higher than what MedPAC simulated in 2000, the impact of this change is likely to be larger today. **The AMA concurs with this discussion from 2000, and we continue to strongly oppose expansion of the SGR or any spending target.** The AMA, however, does not disagree with MedPAC's long-term vision of hospitals and physicians working together in accountable care organizations. The details of this approach are

important. In our view, a mechanism that establishes positive incentives that foster voluntary alliances will have a far greater chance of success than using "top-down" spending targets to drive the development of these kinds of alliances.

Spending Targets And The SGR Undermine The Use Of Health Information Technology And Quality Initiatives

Spending targets are also problematic in that they undermine policymakers' vision of a Medicare health care system that uses health information technology (HIT) and quality initiatives to deliver the highest quality of care to Medicare patients. In fact, spending targets are in direct conflict with this vision because quality initiatives often encourage greater utilization of physicians services through the use of more preventive and chronic disease management services. Yet, the SGR (or other similar spending target) penalizes volume increases that exceed the target through additional payment cuts. Further, these payment cuts destabilize the foundation of the Medicare program and make it nearly impossible for physician practices, which for the most part operate as small businesses, to make the substantial financial investment required for HIT and participation in quality improvement programs. Indeed, a study by Robert H. Miller and others found that initial electronic health record costs were approximately $44,000 per full-time equivalent (FTE) provider per year, and ongoing costs were about $8,500 per FTE provider per year. (*Health Affairs*, September/October, 2005). Initial costs for 12 of the 14 solo or small practices surveyed ranged from $37,056 to $63,600 per FTE provider.

Without positive payment updates, it will be difficult for physicians to make these HIT investments. In fact, a 2006 AMA survey showed that if Medicare physician cuts take effect through 2015, as projected by the Medicare Trustees, 73% of responding physicians will defer purchase of new medical equipment, and 65% will defer purchase of new information technology. Thus, to fulfill policymakers' vision, Medicare payments to physicians must be premised on a stable physician payment system that provides positive payment increases to physicians and accurately reflects increases in physicians' practice costs.

Spending Targets Do Not Achieve Their Goals

Spending targets, such as the SGR inevitably miss the mark because the target is based on a flawed formula that inaccurately estimates Medicare beneficiaries need for physicians' services versus actual consumption of services, and penalizes physicians with pay cuts when they provide needed services that exceed the spending target. Therefore, Congress should not replace one target for another, but should scrap the entire idea of a target, which is fundamentally flawed.

Further, spending targets cannot achieve their goal of restraining volume growth by discouraging inappropriate care. Spending targets apply to a whole group and, therefore, do not provide an incentive at the individual physician level to control spending. In addition, they do not distinguish between appropriate and inappropriate growth because they apply across-the-board to all services. In addition, spending target systems are based on the fallacious premise that physicians alone can control the utilization of health care services, while ignoring patient demand, government policies, technological advances, epidemics, disasters, and the many other contributors to volume growth.

As discussed below, volume growth in physicians' services can be attributed to a number of factors, including government policies, and the AMA cautions the Committee that volume growth does not automatically equate to inappropriate growth. We urge the Committee to ensure that Medicare payment policies are not based on this flawed assumption.

Many Factors Outside Of Physicians' Control
Account For Growth In The Volume Of Health Care Services

A key factor that contributes to the volume growth is that more and more elderly suffer from serious and costly chronic conditions, such as obesity, diabetes, kidney failure, and heart disease. In recent testimony before Congress, Bruce Steinwald, Director of Health Care for the Government Accountability Office (GAO), stated that obesity, smoking, and other population risk factors lead to expensive chronic conditions (including diabetes and heart disease) which drive growth in the utilization of health care resources and spending. Director Steinwald cited research by Kenneth Thorpe attributing 27% of the growth in inflation-adjusted per capita spending between 1987 and 2001 to the rising prevalence of obesity and higher relative per capita spending among obese individuals.

In addition, we are treating diseases earlier, and, as a result of chronic disease intervention and evolutionary changes in the practice of medicine, we have more elderly and disabled Americans living longer, active lives. For example, advances in medical imaging techniques have made it possible to detect cancer at earlier, more treatable stages, target and reduce the side-effects of therapeutic radiation, and pinpoint the impact and treatment of strokes and other conditions.

Another contributing factor to volume growth is that appropriate medical care often requires continued monitoring and sometimes repeated procedures for many patients. For example, an implanted cardiac defibrillator requires two check-up visits a year for the rest of the patient's life.

Moreover, technological advances and changes in Medicare payment policies have facilitated a shift in care from the more expensive hospital setting (*i.e.*, Part A) to physicians' offices (*i.e.*, Part B), which has contributed to increased growth in physicians' offices. Specifically, the National Centers for Vital and Health Statistics (NCVHS) show that hospital days per 1000 population between 1995 and 2002 declined by more than 15% among 65 to 74 year olds and by more than 10% for those 75 and older. Over that same period, as physicians filled the gaps in care created by earlier hospital discharges and increasingly treated patients outside the hospital, seniors' office visits rose by 24%. Quality improvement initiatives that focus on gaps in care have also reached out to more beneficiaries, which, in turn, has increased volume in physicians' offices. This trend may continue as the Medicare physicians reporting program, enacted under H.R. 6111, the "Tax Relief and Health Care Act of 2006," is implemented on July 1 of this year. Quality initiatives have led to fewer hospital admissions, shorter lengths of stay, longer life spans with better quality of life, and fewer restrictions in activities of daily living among the elderly and disabled.

Finally, government policies substantially contribute to increased services in physicians offices, especially those that promote new Medicare benefits for preventive care services (such as Medicare coverage of an initial preventive physical examination for new Medicare enrollees). These policies also include national coverage decisions (NCDs) by which CMS announces changes and expansions in Medicare benefits, which increases spending on physicians' services. Although CMS issued over 100 NCDs between 1999 and 2006, the agency has not reflected the full impact on physician spending due to such expansions in Medicare benefits when setting the SGR spending target for physician's services. In testifying before Congress this last month, Bruce Steinwald, of the GAO, stated that "[w]hat we do in this country, basically, through our approval processes and our coverage processes in both public and private sector is rather than control the spigot and control the flow of technologies at the spigot, we basically turn the spigot on full force and then stick our thumb in the bottom to see if we can gain control, and that's not a very efficient way of doing it."

The foregoing discussion suggests that while a number of factors drive appropriate volume growth, this spending on physicians' services is a good investment. For example, over the last decade, life expectancy has risen for both women and men, and 65-year-olds of both sexes can now expect to become octogenarians. Further, mortality rates in this century have been falling by about 3% a year for certain prevalent diseases such as heart, stroke, and other cerebrovascular disease, while deaths from cancer have declined by about 1% a year over the last decade. Specifically, the National Center for Health Statistics recently reported that there were 50,000 fewer U.S. deaths in 2004, the biggest single-year drop in mortality since the 1930s. Not only are beneficiaries living longer, they are living better. Thousands of stroke, hip fracture, emphysema, and heart failure patients who once would have faced a bed-ridden future now are rehabilitated and return home to relatively independent lives.

We urge Congress, in developing a new physician payment system, to ensure that the first priority is to meet the health care needs of our elderly and disabled patients. To achieve this goal, Congress and policymakers should not impose spending targets that penalize all physicians through a formula tied to volume growth. **Where inappropriate volume growth is identified in a particular type of medical service, Congress, CMS, and organized medicine should address it through development of the mechanisms described in the "Joint Recommendations" referenced above. This would allow Congress and CMS to deal with the source of the increase, thereby ensuring more control over the process than exists under the current system.**

MedPAC's Identification Of Possible Modifications To The SGR

In addition to recommending alternative solutions to the SGR, MedPAC has identified methods for modifying the SGR formula to make it somewhat less onerous. MedPAC has identified certain options, including:

- Eliminating the cumulative feature of the SGR and instead using annual targets so that multiyear deficits in target spending will not accrue and lead to multiyear pay cuts;
- Increasing the SGR target for utilization growth per beneficiary to GDP + 1 rather than GDP alone; and

- Setting a corridor that limits physician payment updates to within 2% of the MEI instead of the current limits of MEI plus three and minus seven.

The AMA continues to believe that repeal, not modification, of the SGR is the best solution. Each of the foregoing options would leave in place a flawed payment formula and would not likely lead to positive physician payment updates in the future. Combining all of the options would make positive future updates more likely than under the current formula. Yet, the cost of enacting these combined modifications is likely to be nearly as much as repealing the SGR and replacing it with MEI updates.

Application Of The SGR To Smaller Units

As directed by Congress, MedPAC also examined the pros and cons of various "mini SGRs," which would apply an SGR-like target based on specialty, service category, geographic region, medical groups, hospital medical staffs, and outlier physicians. Again, the AMA urges repeal of the SGR, and we do not support adoption of mini-SGRs, which we believe would be just as problematic as the current SGR system. "Mini-SGRs" would still impose an arbitrary and inaccurate spending target that relies on unpredictable assumptions that often bear very little relationship to the health care needs of our Medicare patients. More importantly, unless these "mini-SGRs" begin in a "deep hole" with negative updates, these alternatives would be very costly.

An analysis by AMA economists suggests that reversing the current projected cuts, due to the SGR, would require a combination of options with costs that are close to price tag that the Congressional Budget Office has calculated for MedPAC's original proposal to repeal the SGR and replace it with MEI updates. This price tag is significant, but without a substantial infusion of funds, the SGR, with its inevitable steep cuts, will continue to dictate enactment of short-term fixes that only increase the cost of long-term solutions. We remind the Committee that CMS can help significantly reduce the cost of repealing the SGR through immediate administrative actions, as discussed below.

ADMINISTRATIVE ACTIONS TO REDUCE THE COST OF REPEALING THE SGR

We urge the Committee to press CMS to assist Congress in repealing the flawed SGR formula through immediate administrative actions that would significantly reduce the cost of such repeal.

CMS Should Remove Drug Costs Retroactively From The Calculation Of The SGR

When CMS identifies Medicare spending on "physicians' services" for purposes of calculating the SGR, it includes the cost of Part B physician-administered drugs. Yet, CMS has the discretion to exclude the drugs from this definition of "physicians' services." Further, CMS has the legal authority to remove these physician-administered drugs from the SGR retroactive to 1996, thus far the agency has declined to do so despite requests from this Committee, as well as other Congressional leaders and organized medicine. In July 2005, 89

Senators and virtually all Members of the Committee signed a letter to the Office of Management and Budget (OMB) Director urging the Administration to remove the cost of these drugs from the SGR calculations.

It is also inequitable to include drug expenditures in calculations of the SGR because drugs continue to grow at a very rapid pace. For example, spending for only one recently-developed drug, Pegrilgrastim (Neulastra) totaled $518 million in 2004, thus accounting for a significant proportion of Medicare spending growth under the SGR. Further, drug expenditure growth has far outpaced that of the physician services that the SGR was intended to include, and Medicare actuaries predict that drug spending growth will continue to significantly outpace spending on physicians' services for years to come. This lopsided growth lowers the SGR target for actual physicians' services and significantly increases the odds that Medicare spending on "physicians' services" will exceed the SGR target. In 1996, drug spending was less than 4% of SGR spending. By 2005, it had grown to 9% and by 2017 it could be nearly 20%. **While the AMA supports the significant benefits that these drugs provide to patients, it is not equitable or realistic to include the cost of these drugs in the SGR, and CMS should remove them retroactively to 1996.**

Medicare Physician Spending Due To
National Coverage Decisions (NCDs) Should Be Reflected In The SGR

When establishing the SGR spending target for physicians' services, CMS, by statute, is required to take into account the impact on physician spending due to changes in laws and regulations. Changes in national Medicare coverage policy that are adopted by CMS pursuant to a formal or informal rulemaking, such as Program Memorandums or national coverage decisions (NCDs) which implement coverage change and expansions, constitute a regulatory change. Yet, CMS does not reflect the impact on physician spending due to NCDs when calculating the SGR target. As discussed above, CMS has issued over 100 NCDs from 1999 through 2006.

When the impact of NCD expansions on physician spending is not taken into account for purposes of the SGR, this causes aggregate physician spending to exceed the SGR target at even greater rates. For example, CMS has used the NCD process to either: (i) reverse a previous decision not to cover; or (ii) to expand current Medicare coverage for positron emission tomography (PET scans), bariatric surgery for treatment of obesity, transluminal percutaneous angioplasty with carotid artery stents, and ocular photodynamic therapy with Verteporfin for patients with macular degeneration. These NCDs add considerably to spending under the SGR but, by not counting such benefit expansions as changes in law and regulation for purposes of calculating the SGR, they increase the likelihood of SGR-driven pay cuts.

Physicians are then forced to finance the cost of these program changes and expansions through cuts in their payments. Not only is this supposed to be precluded by the SGR law, it is extremely inequitable and ultimately could adversely impact beneficiary access to important services. CMS has stated its view that it would be very difficult to estimate any costs or savings associated with specific coverage decisions and that any adjustments would likely be small in magnitude and have little effect on future updates. **Yet, CMS already adjusts Medicare Advantage payments to account for NCDs, so it clearly is able to**

estimate their costs. Thus, CMS should include the impact on physician spending due to these NCDs for purposes of calculating the SGR.

MEDICARE BENEFICIARY PREMIUMS

As we work to repeal the SGR, CMS and policymakers have noted that an increase in Medicare payments for physicians and other health professionals would, in turn, increase the Medicare Part B premium for beneficiaries. Physician pay cuts, however, will ultimately cost beneficiaries more because these cuts will force physicians to discontinue providing certain services in the physician's office or force longer wait times for a physician office visit. Rather, patients will have to receive these services in higher-cost hospital or emergency department settings. This means that Medicare patients will experience more inconvenience and higher deductibles and co-payments when they are treated in the hospital.

Further, increased spending on other services, such as hospital outpatient services also increases beneficiary premiums, yet, as discussed above, other providers continue to receive payment updates that keep pace with their medical inflation. In announcing Medicare premiums for 2007, CMS stated that "very rapid growth in hospital outpatient services is a major contributor to the premium increase. Although outpatient hospital spending accounts for only about 13 percent of total Part B spending, it accounts for one-third of the increase in the 2007 premium." In fact, spending for physician fee schedule services accounted for only about 14% of the increase in the Medicare premium for 2007. Accordingly, updates to all providers contribute to premium increases, and the AMA asks to have parity with these other providers.

Finally, we note that according to CMS, about one in four Medicare beneficiaries are protected from premium increases because they can get extra assistance that enables them to pay little to no premium for Medicare Part B services.

The AMA appreciates the opportunity to provide our views to the Committee on MedPAC's report and other critical matters. We look forward to working with the Committee and Congress to repeal the SGR and avert its resulting cuts, initiate mechanisms to assure appropriate use of physicians' services, and preserve patient access to high quality, cost-effective care.