



Statement

of the

American Medical Association

to the

**Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives**

**RE: Medicare Physician Payment:
How to Build a More Efficient
Payment System**

Presented by: Duane M. Cady, MD

November 17, 2005

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The American Medical Association (AMA) appreciates the opportunity to provide our views today regarding the urgent need for Congressional action to replace steep Medicare physician pay cuts with positive updates for at least the next two years, giving Congress and the Administration time to enact a permanent solution to the fatally flawed Medicare physician payment formula. Pending physician pay cuts will affect nearly one million physicians and other health care professionals whose Medicare payment rates are determined by the Medicare physician fee schedule.

Physicians have been working with Congress over the last several years to achieve a solution to the Medicare physician payment formula. A permanent solution to this problem is critical for maintaining access to and quality of care for Medicare patients. In fact, in 2004, the Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan, MD,

underscored to Congress the agency's "concern about making sure that Medicare payments to physicians are adequate and encourage better care, because physician decisions can have such a critical impact on all Medicare costs and on patient health." That statement still rings true today. Indeed, there is widespread agreement – from many in Congress (both sides of the aisle) and the Medicare Payment Advisory Commission (MedPAC) – that the physician payment formula should be scrapped altogether. Further, Congress and CMS agree that an adequate payment structure for physicians is vital for maintaining a strong foundation under which Medicare can properly provide quality health care for our nation's seniors and disabled citizens. Yet, here we are today, with 44 calendar days until a 4.4% Medicare physician pay cut goes in effect. Congress must act now, or the foundation upon which the Medicare program is built will crumble.

CONGRESSIONAL ACTION NEEDED THIS YEAR
TO STOP MEDICARE PHYSICIAN PAY CUTS

CMS recently confirmed that Medicare physician payments will be cut by 4.4%, effective January 1, 2006. This will be the first in a series of cuts projected over the next six years by the Medicare Trustees, with cumulative cuts of 26% from 2006 through 2011. Congress must act this year to stop the pending cuts and provide positive payment updates for at least 2006 and 2007. This will help preserve access to health care services for seniors and persons with disabilities while Congress and the Administration jointly work to enact a permanent fix to the current Medicare physician payment formula.

**FUNDAMENTAL PROBLEMS WITH THE FATALLY FLAWED
MEDICARE PHYSICIAN PAYMENT FORMULA: THE SGR**

A fatally flawed Medicare physician payment update formula – called the sustainable growth rate (the SGR) – is responsible for the projected cuts. Under the SGR, payment updates are tied to GDP growth, which factors in neither patients’ health care needs nor physicians’ practice costs. Physicians are penalized with pay cuts when Medicare spending on physicians’ services exceeds SGR spending targets that are based on GDP growth, but make no allowance for government policies and other factors that increase utilization of services.

Because of these fundamental defects, the SGR led to a negative 5.4% update in 2002, and additional reductions in 2003 through 2005 were averted only after Congress intervened and replaced projected steep negative updates with positive updates of 1.6% in 2003 and 1.5% in each of 2004 and 2005. We greatly appreciate these short-term reprieves. Even with these increases, however, Medicare physician payment updates during these years were only about half of the rate of inflation of medical practice costs. To make matters worse, if the 2006 cut is imposed, average physician payment rates will actually be less in 2006 than they were in 2001 (in real terms, not adjusted for inflation). Further, a 4.4% cut in January 2006, would mean that from 2002-06, payment rates will have fallen 16% behind the government’s index of inflation in physicians’ practice cost.

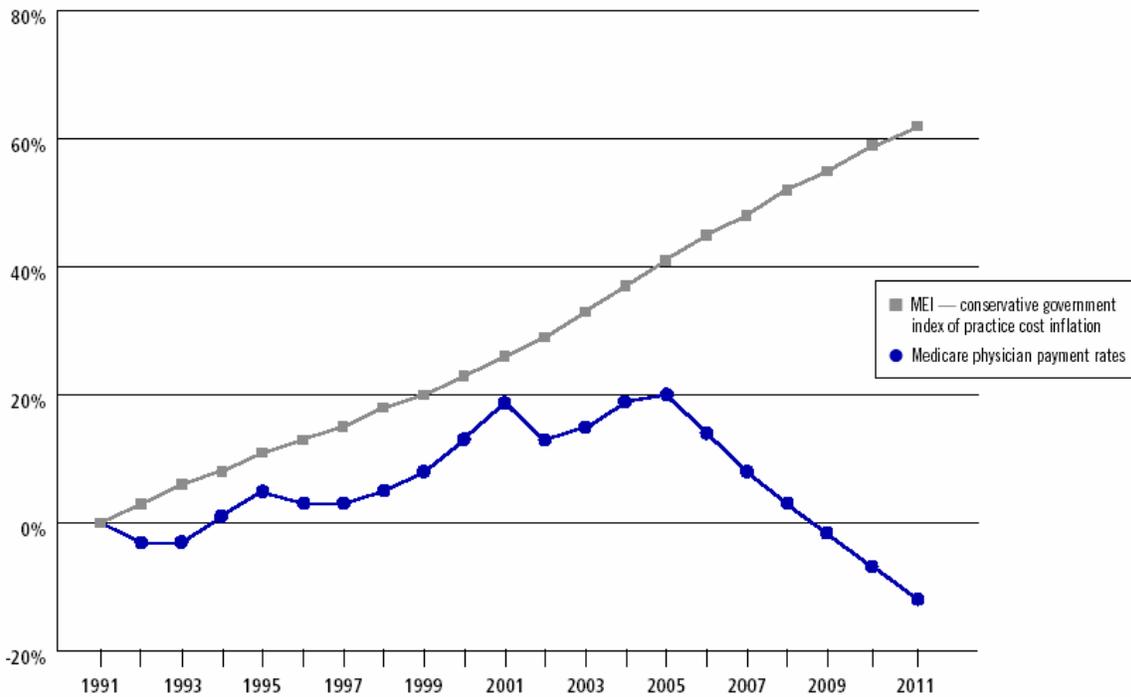
As shown by the graph below, these reductions come at a time when, even by Medicare’s own conservative estimate, physician practice costs are expected to rise by an additional 15% from 2006-11 (with Medicare physician payments decreasing by 26%). The vast majority of

physician practices are small businesses, and the steep losses that are yielded by what is ironically called the “sustainable growth rate,” would be unsustainable for any business, especially small businesses such as physician office practices.

The **UN**-Sustainable Growth Rate

2006 through 2011:

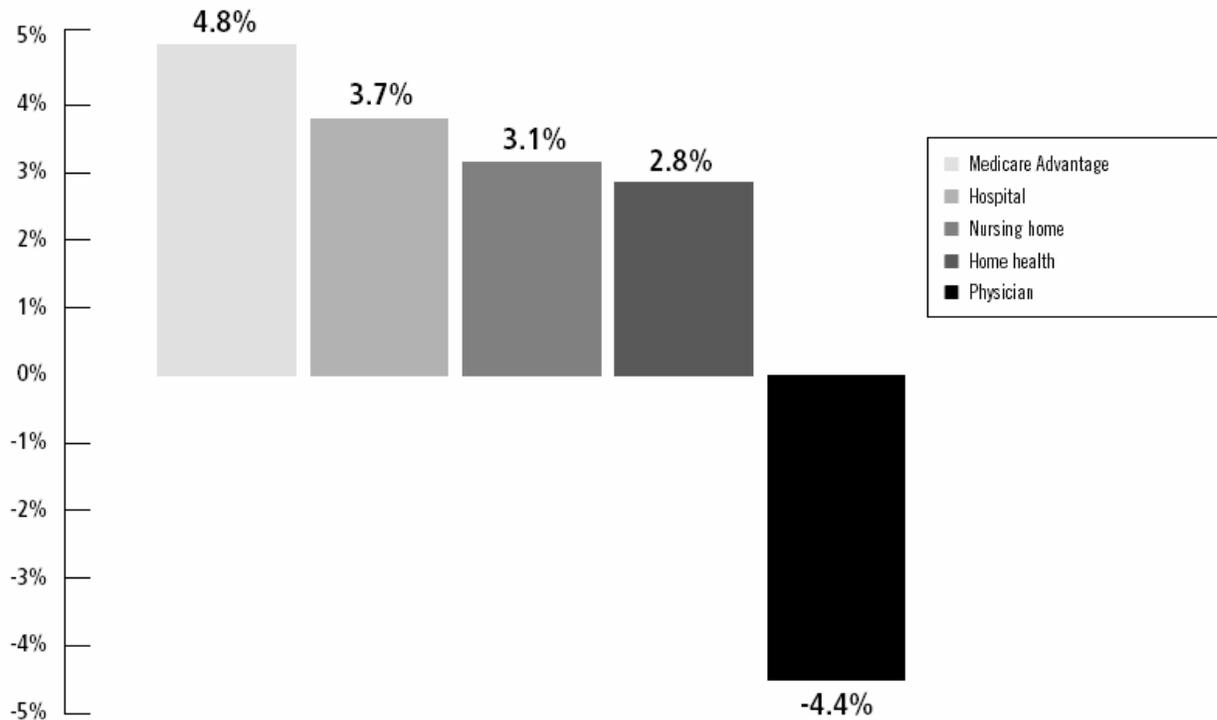
Physicians’ costs up 15 percent; Medicare payments down 26 percent



Sources: Medicare Economic Index (MEI) and payment projections from the Centers for Medicare & Medicaid Services (CMS) and 2005 Medicare Trustees report. Chart by AMA Division of Economic and Statistical Research.

Only physicians and health professionals face updates of 7% below the annual increase in their practice costs. Hospitals and long-term care providers are slated for updates that fully keep pace with their market basket increases, and Medicare Advantage plans will see average updates of 4.8% in 2006, as illustrated in the bar graph below. Medicare physician payments must be re-structured to ensure access for fee-for-service patients as well.

Projected 2006 Medicare payment updates



Sources: Projected updates based upon best available information from the Centers for Medicare & Medicaid Services as of November 2005.

ACCESS PROBLEMS FOR MEDICARE BENEFICIARIES UNDER THE CURRENT MEDICARE SGR PHYSICIAN PAYMENT FORMULA

Physicians simply cannot absorb the pending draconian payment cuts. In fact, a recent AMA survey indicates that if the cuts begin January 1, 2006:

- More than a third of physicians (38%) would decrease the number of new Medicare patients they accept;
- More than half of physicians (54%) plan to defer information technology purchases;

- A majority of physicians (53%) would be less likely to participate in a Medicare Advantage plan; and
- One-third (34%) of physicians whose practice serves rural patients would discontinue their rural outreach services.

A physician access crisis is looming for Medicare patients. More than 20 states each face cuts in Medicare funding of more than one billion dollars from 2006-2011. The MMA promised important new benefits for patients. An adequate payment structure for physicians' services must be in place in order for the government to deliver on its promise of these important benefits.

Yesterday, Medicare patients began enrolling for the new Medicare drug benefit that will become effective January 1, 2006. **Physicians are the foundation of our nation's health care system, and Medicare patients' access to physicians' services is imperative for the success of the new prescription drug benefit.** Continual cuts put such access at risk.

Indeed, there are already signs that access to care is deteriorating. A MedPAC survey found that 22% of patients already have some problems finding a primary care physician and 27% report delays getting an appointment.

The physician cuts that threaten to destabilize the Medicare program will also create a ripple effect across other programs. Indeed, these cuts jeopardize access to medical care for millions of our active duty military family members and military retirees because their TRICARE insurance ties its payment rates to Medicare. The Military Officers Association of America

(MOAA) recently sent a letter to Congress urging Congressional action to avert the 4.4% cut because it will “significantly damage” military beneficiaries’ access to health care services. MOAA stated that “[w]ith our nation at war, Congress should make a particular effort not to reduce health care access for those who bear and have borne such disproportionate sacrifices in protecting our country.”

**MEDICARE QUALITY OF CARE INITIATIVES DEPEND ON
ADEQUATE PHYSICIAN PAYMENT STRUCTURE**

An adequate Medicare physician payment structure is also imperative for Medicare quality of care initiatives. There is a growing consensus that greater physician adoption of information technology is vital to improvements in quality of care. Unless physicians receive positive payment updates, however, these investments will not be possible.

Further, inclusion of value-based purchasing (or pay-for-performance) provisions as part of any final budget reconciliation bill, without a long-term solution to the SGR, will only compound the looming access problem and make future SGR reforms more expensive.

Value-based measures will lead to higher volume of physicians’ services. Under the SGR formula, more services will result in more cuts. **Value-based purchasing and the SGR formula are incompatible. The SGR formula needs to be repealed in order for value-based purchasing proposals to succeed.**

PERMANENT SOLUTION TO THE SGR IS NEEDED
TO PROTECT PATIENT ACCESS AND QUALITY OF CARE

The Medicare physician payment problem continues to exist because, as discussed above, it is inherently flawed and has led to deep cuts that were not projected when the formula was implemented in 1997. While we greatly appreciate the short-term reprieves achieved by Congress and the Administration in recent years, these temporary fixes have led to even deeper and longer sustained cuts because Congress recouped the cost of temporarily blocking the severe cuts in physician payments in the out-years. Without a long-term solution, repeated Congressional intervention will be required to block payment cuts that jeopardize continued access to high quality care for the elderly and disabled. A one-year fix would provide a temporary respite and lead to another struggle to deal with this problem early next year. **Thus, at least a two-year fix is urgently needed this year to allow time for a permanent solution to the SGR.**

Some government officials have cited the SGR formula as a method for restraining the growth of Medicare physicians' services. Yet, there are many reasons for such growth, and there are no studies documenting systematic inappropriate care. Without valid studies, it is impossible to determine what volume growth is appropriate or inappropriate. Earlier this year, for example, Medicare officials announced that spending on Part A services is decreasing. This suggests that, as technological innovations advance, services are shifting from Part A to Part B, leading to appropriate volume growth on the Part B side. If there is a problem with volume growth regarding a particular type of medical service, the AMA looks forward to working

with Congress and the Administration to address it, rather than retaining a formula that penalizes both patients and physicians for growth that may not be inappropriate at all.

ADMINISTRATIVE ACTION NEEDED
TO ASSIST CONGRESS IN REPLACING THE SGR

CMS Administrator McClellan recently stated that “the current system of paying physicians is simply not sustainable.” We agree and urge the Subcommittee to continue pressing CMS to use its authority to take administrative action to help Congress avert physician pay cuts and ensure that a stable, reliable Medicare physician payment formula is in place for Medicare patients.

Despite their protestations, the AMA firmly believes that CMS has the authority to remove the costs of drugs, back to the base period, from the calculation of the SGR. Because this would significantly reduce the cost of legislation and allow Congress to address the looming Medicare pay cuts more easily, CMS should take this step as soon as possible. Indeed, CMS told Congress earlier this year that removing drugs prospectively is worth about \$36 billion in lowered costs, while removing them from the base-year forward reduces \$111 billion from the cost of an ultimate fix.

Drug expenditures are continuing to grow at a very rapid pace. Over the past 5 to 10 years, drug companies have revolutionized the treatment of cancer and many autoimmune diseases through the development of a new family of biopharmaceuticals that mimic compounds found within the body. Such achievements do not come without a price. For example, in 2004 alone, six oncology drugs received FDA approval or expanded approval, and two others

received approval in 2003. As Dr. McClellan noted in testimony earlier this year, spending for one recently-developed drug, Pegrilgrastim (Neulasta) totaled \$518 million last year, more than double the 2003 total. This drug strengthens the immune systems of cancer patients receiving chemotherapy, thereby improving and extending the lives of many and potentially reducing hospital costs in the process.

Growth rates for drug spending dwarf those of the physician services the SGR was intended to include. Between the SGR's 1996 base year and 2004, the number of drugs included in the SGR pool rose from 363 to 445. Spending on physician-administered drugs over the same time period rose from \$1.8 billion to \$8.6 billion, an increase of 358% per beneficiary compared to an increase of only 61% per beneficiary for actual physicians' services. As a result, drugs are consuming an ever-increasing share of SGR dollars, nearly tripling from 3.7% of total SGR spending in 1996 to 9.8% in 2004.

It is not equitable or realistic to finance the cost of innovative drug therapies through cuts in payments to physicians and other health care professionals. CMS must act now to remove these costs from calculations of the SGR. The longer CMS waits to make this policy change, the more costly it will be for the government to do so.

The AMA appreciates the opportunity to provide our views to the Subcommittee on these important matters. We look forward to working with the Congress and the Administration to: (i) stop the pending Medicare cuts; (ii) provide at least two years of

positive Medicare physician payment updates beginning in 2006; and (iii) defer implementation of value-based purchasing proposals until the SGR is repealed and replaced with a formula that does not unfairly penalize physicians for volume increases. These measures will assist the Medicare program in providing broad-based access and quality of care for seniors, persons with disabilities, and military beneficiaries.