

November 10, 2011

The Honorable Patty Murray
Co-Chair
Joint Select Committee on Deficit Reduction
448 Russell Senate Office Building
Washington, DC 20510

The Honorable Jeb Hensarling
Co-Chair
Joint Select Committee on Deficit Reduction
129 Cannon House Office Building
Washington, DC 20515

Dear Senator Murray and Representative Hensarling:

On behalf of the undersigned members of the Coalition of State Medical and National Specialty Societies, we urge you to take this unique opportunity to recommend reforms that will ensure that the Medicare program remains viable into the future so millions of seniors and disabled Americans continue to receive timely quality access to care. As the Joint Committee moves into the homestretch of its deliberations, we realize the enormity of your task and encourage you to make every effort to reach an agreement that addresses our nation's fiscal challenges, while at the same time improving vital health care programs.

The Coalition has come together with a common commitment to preserve the practice of medicine as a profession, and to preserve the time-honored patient-physician relationship keeping it free of outside interference. To that end, we have several specific recommendations for the Joint Committee that will further this mission including:

- ❖ Reforming the Medicare Physician Payment System
- ❖ Adopting Meaningful Medical Liability Reform; and
- ❖ Repealing the Independent Payment Advisory Board

Reforming the Medicare Physician Payment System

Medicare is the nation's largest government-run health care program, and it represents the most glaring example of the need for change. The current sustainable growth rate (SGR) physician payment system, in particular, is failing to serve our nation's seniors and physicians. Baby boomers are now entering the Medicare program, there is a shrinking pool of primary care and specialty physicians, and it is increasingly difficult for seniors and the disabled to find doctors who accept new Medicare patients as the gap between government-controlled payment rates and the cost of running a practice grows wider. Our Coalition is therefore convinced that the key to preserving our Medicare patients' access to quality medical care is overhauling the flawed Medicare payment system.

- **Repealing the SGR.** As you know, due to the flawed sustainable growth rate (SGR) formula, physicians face a 27.4 percent payment cut on January 1, 2012 and the Congressional Budget Office (CBO) has indicated that by 2014, the cumulative reduction in the rates will be about 40 percent. Congress' repeated failure to provide a permanent fix for Medicare's SGR not only jeopardizes Medicare patients' access to timely medical care, but it also is a major contributor to our country's long-term deficit problem since the cost of repeal grows even higher each year Congress fails to act. It is therefore essential that the Joint Committee recommend full repeal of the SGR and replace this system with a stable mechanism for paying physicians.
- **Allowing Patients and Physicians the Right to Privately Contract.** An essential element of Medicare payment reform is allowing patients and physicians to voluntarily enter into arrangements known as private contracts. The right to privately contract for services is a

touchstone of American freedom and liberty. Patients and physicians must be allowed to freely exercise this right without third party interference or penalty. Private contracting is one way that the federal government can achieve fiscal stability while fulfilling its promise to Medicare beneficiaries. A patient who chooses to see a physician outside the Medicare system should not be treated as if he or she doesn't have insurance. Medicare should pay its fair share of the charge and allow the patient to pay the balance. It is also the only way to ensure that our patients can maintain control over their own medical decisions. The government has the right to determine what it will pay toward medical care, but it doesn't have the right to determine the value of that medical care. This value determination should ultimately be made by the individual patient.

Legislation called the Medicare Patient Empowerment Act (H.R. 1700 and S. 1042) has been introduced in Congress and we urge the Joint Committee to include it in its recommendations. The Medicare Patient Empowerment Act would establish a new Medicare payment option whereby patients and physicians would be free to contract for medical care without penalty. It would allow these patients to apply their Medicare benefits to the physician of their choice and to contract for any amount not covered by Medicare. Physicians would be free to opt in or out of Medicare on a per-patient basis, while patients could pay for their care as they see fit and be reimbursed for an amount equal to that paid to "participating" Medicare physicians.

- **Keeping the Determination of Quality in the Hands of Physicians.** One our Coalition's founding principles is that the determination of the quality of medical care must be made by the profession of medicine, not by the government or other third party payers. Unfortunately, a growing number of so-called quality improvement programs are being forced on physicians, despite little evidence, if any, that they actually do anything to improve the quality of care provided to patients. Some have suggested that Congress accelerate the adoption of such programs and that the that the SGR be replaced with a new payment system that no longer reimburses physicians for the quantity of services they provide, but rather pays doctors based on the quality and value of care they deliver. While Congress has taken the first steps towards implementing quality improvement payment programs – for example, the Physician Quality Reporting System (PQRS) and shared savings pilots such as accountable care organizations and bundling -- it has yet to be demonstrated that these programs will lower Medicare costs and result in better patient outcomes. We therefore encourage the Joint Committee to reevaluate the wisdom of these programs and include recommendations to rescind the PQRS, electronic prescribing and health information technology penalties; repeal the budget-neutral value-based payment modifier; and delay the expansion of the physician quality and resource use programs until such time as valid risk adjusted clinical outcomes data is available.

Adopting Meaningful Medical Liability Reform

The medical litigation system in the U.S. has steadily deteriorated as direct and indirect costs have increased. Patients, meanwhile, are finding it increasingly difficult to secure access to care. As we've stated in the past, the inefficiencies associated with our current medical liability system, coupled with escalating and unpredictable awards and the high cost of defending against lawsuits -- even those without merit -- have contributed to medical liability insurance premiums that are at or near all-time highs. As medical liability insurance becomes unaffordable or unavailable, a growing number of physicians are avoiding high-risk procedures or they're moving to states with stable medical liability systems or they're simply retiring from medical practice -- all of which will have disastrous results for the patients who require critical lifesaving services. Additionally, defensive medicine adds billions of dollars to the cost of health care each year, increasing individual health insurance premiums.

Reforms based on those in place in California and Texas have provided stability in the medical liability insurance market, lowered costs and improved access to care, while at the same time providing just and fair compensation for patients injured by medical negligence. The Joint Committee should recommend the adoption of these reforms, which include:

- A \$250,000 cap on noneconomic damages;
- A sliding scale cap on attorney fees;
- Collateral source rule reform with a ban on subrogation;
- Periodic payment of future damages; and,
- A three year from incident/one year from discovery statute of limitations.

The Congressional Budget Office (CBO) has calculated that such reforms will save the federal government some \$62 billion over 10 years -- resources that could be used to improve our current health care delivery system.

Repeal the Independent Payment Advisory Board

Medicare payment policy requires a broad and thorough analysis of the affects on all providers and beneficiaries and from the beginning of Medicare, Members of Congress have played an essential role in shaping policies that best meet the needs of their communities and their constituents to ensure that the health care system is equipped to care for diverse populations across the country. Unfortunately, the Independent Payment Advisory Board, or IPAB, created by the Patient Protection and Affordable Care Act (PPACA), threatens the ability of the people's elected representatives in Congress to ensure that patients have access to the health care they need, when they need it.

The many problems with IPAB include the following:

- The IPAB will consist of 15 members appointed solely by the President, fewer than half of the IPAB members can be health care providers, and none are permitted to be practicing physicians or be otherwise employed;
- IPAB will be required to recommend cuts based on unrealistic spending targets starting in 2014 and its recommendations are "fast tracked" and automatically go into effect starting in fiscal year 2015 unless blocked or amended by Congress;
- Providers representing roughly 37 percent of all Medicare payments, including hospitals and hospice care, are exempt from IPAB cuts until 2020; thus IPAB directed cuts will disproportionately fall on physicians and other providers;
- Without a permanent solution to the Medicare's sustainable growth rate (SGR) formula, physicians are essentially subject to "double jeopardy" with cuts from both the SGR and IPAB; and
- The IPAB eliminates the transparency of hearings, debate and the meaningful opportunity of stakeholder input.

While we recognize the need to reduce the federal budget deficit and control the growth of health care spending, the IPAB is simply the wrong solution for addressing these budgetary challenges. We need a workable alternative that adequately reimburses physicians and ensures that patients will have timely access to quality care, and leaving Medicare payment decisions in the hands of an unelected, unaccountable governmental body with minimal congressional oversight will not accomplish these goals. Today, the price tag for repealing the IPAB is relatively small, so Congress should seize this moment and repeal the IPAB now before the cost to do so becomes prohibitive and access to care problems become acute. Additionally, because IPAB funding was authorized to begin on October 1, 2011 and board members can now be appointed, there is urgency for repeal before this board is ever up and running.

Thank you for considering our input. We understand the difficult choices you must make over the next few weeks and commend you for your efforts to date. If you have any questions or need additional information, please contact Katie O. Orrico at 202-446-2024 or korrico@neurosurgery.org.

Sincerely,

Medical Association of the State of Alabama
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association
Medical Association of Georgia
Kansas Medical Society
Louisiana State Medical Society
South Carolina Medical Association
American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American Society of General Surgeons
Congress of Neurological Surgeons

Past Presidents of the American Medical Association

Donald J. Palmisano, MD, JD, FACS
AMA President 2003-2004

William G. Plested, III, MD, FACS
AMA President 2006-2007

cc: Members, Joint Select Committee on Deficit Reduction
The Hon. John Boehner, Speaker, U.S. House of Representatives
The Hon. Nancy Pelosi, Minority Leader, U.S. House of Representatives
The Hon. Harry Reid, Majority Leader, U.S. Senate
The Hon. Mitch McConnell, Minority Leader, U.S. Senate