



The Key to Good Health

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December 15, 2010

National Commission on Fiscal Responsibility
The Honorable Erskine Bowles, Co-Chairman
The Honorable Alan Simpson, Co-Chairman
1650 Pennsylvania Ave NW
Washington, DC 20504

Dear Chairmen Bowles and Simpson:

As the Alliance of Specialty Medicine (Alliance), our mission is to advocate for sound federal health care policy that fosters patient access to the highest quality specialty care and improves timely access to high quality medical care for all Americans. As patient and physician advocates, we commend your efforts to cut the nation's debt by nearly \$4 trillion and recognize the difficulties in taking on the necessary tasks of proffering real world solutions to our nation's debt crisis.

The Alliance understands that reducing health care costs will need to be a part of a comprehensive effort to reduce the national deficit. We commend the effort the Commission members have made to identify extensive and diverse cost cutting measures. Any successful proposal will need to equitably spread those measures amongst all aspects of government (defense, education, transportation, etc) and all aspects of the healthcare industry (insurers, hospitals, drug companies, device manufacturers, health care workers, employers and patients). As written however, the Commissions proposal places an excessive share of responsibility in cutting Medicare costs on physician providers.

Since physicians are the "face" of medicine, the general perception is that physicians account for the vast majority of health care expenditure. The Alliance would like to point out to the Commission that, according to the Centers for Medicare and Medicaid Services (CMS) 2011 budget estimates, physician reimbursement accounts for only 9.6% of total Medicare expenditure. Conversely, other areas not specifically targeted for cuts encompass much larger percentages of Medicare spending. CMS estimates that total hospital spending (inpatient and outpatient) will comprise 32.6% of all Medicare expenditures in 2011, managed care will consume 24% of expenditures and the drug benefit 13%.¹ These other

¹ Department of Health and Human Services. 2011 Budget in Brief. <http://www.hhs.gov/asfr/ob/docbudget/2011budgetinbrief.pdf>.

stakeholders must shoulder an appropriate increased responsibility in the planned cost savings measures.

The Alliance fully supports proposals to repeal Medicare's Sustainable Growth Rate formula (SGR) and the use of federal medical liability reforms to offset the significant cost associated with this change in policy. Physician reimbursement driven by the SGR formula fails to adequately reimburse physicians for the costs associated with the care they provide to Medicare beneficiaries and contributes to increasing access to care issues for the elderly. The SGR is updated by setting an overall target amount of spending (measured on both an annual and a cumulative basis) for all goods and services provided under Medicare Part B. Costs for Medicare Part B are determined not just by payments for physician services, but costs for laboratory tests, the technical component of imaging services, drugs administered in certain settings and various other expenditures. This formula holds physicians accountable for costs for which they have no control, resulting in scheduled cuts. Physician received a 5.0% increase in reimbursements in 2001. Since 2002, the SGR has called for reductions in Medicare Part B reimbursements. Physician reimbursements were cut by 4.8% in 2002, with additional cuts being averted by Congress each year since. As a result of Congressional action, physicians have seen average yearly increases of less than one percent since 2004, with no update in 2006 or 2007.² Over the same period of time, other Medicare providers have seen significant yearly updates in reimbursement. Medicare Advantage reimbursements have increased on average 5.32% annually since 2004, with hospitals and nursing homes receiving increases of 3.47% and 3.12% respectively. Attempts to decrease the deficit that focus on health care costs should take into consideration all Medicare expenditures and in particular identify expenditures that constitute higher proportions of overall expenditure and expenditures that have received generous updates over the past years.

Physicians recommend and provide care for Medicare beneficiaries that they feel is ethical, compassionate and medically appropriate. If the physician recommends an extra day of stay in a hospital or a specific treatment modality, it is generally because this is felt to be in the best interests of the patient. The costs for this care, whether hospitalization or nursing homes, drugs, imaging and other benefits, are not under the control of physicians. Physicians do not control costs associated with other stakeholders such as hospitals or drug companies. Targeting physician reimbursements, which currently account for only 9.6% of Medicare outlays, for further reduction would be inappropriate, result in physicians opting out of Medicare, and likely result in long term shortages in physician supply. The Alliance does not support replacing cuts required by the SGR with a freeze in Medicare physician reimbursements through 2020, while the CMS develops and implements alternative payment structures. Physicians already realize a 20% gap in the difference between Medicare reimbursement and the cost of providing care to seniors, as a result of a series of patches that froze or incrementally increased reimbursements while health care costs continued to rise exponentially. The Alliance supports the study of alternative payment systems that may have the ability to provide better quality of care to patients and reduce costs within the health care system, and better identify direct physician reimbursement expenditure.

The Alliance recommends investing in research to determine the most cost effective means for providing high quality care, which should result in significant cost savings over time. Alliance members are actively engaged in the process of developing evidence-based and clinically relevant quality measures. Alliance member organizations are also developing massive national patient data registries in their respective specialties which will identify highest quality and value care to Medicare beneficiaries.

² Centers for Medicare and Medicaid Services. 2010 Sustainable Growth Rate Conversion Facts. <http://www.cms.gov/SustainableGRatesConFact/Downloads/sgr2010f.pdf>.

The Alliance strongly supports appropriately structured comparative effectiveness research and would encourage the Commission to support funding for physicians and specialty medicine organizations to conduct such research and data registries. These types of activities will produce long-term cost savings in the health care system and higher quality care, by establishing the most appropriate care for patients and emphasizing payment for the best possible treatment plan for each individual patient.

The Alliance believes that state-tested and proven successful medical liability reforms like those in Texas and California are the most effective way to end the defensive medicine practices that add billions in unnecessary spending to the health care system, and supports any attempt to enact these on the federal level. Currently, the medical liability climate facing our nation's physicians and patients creates a financial burden on the health care system and promotes inefficiencies that fail to protect patient access to quality care. The costs of our liability system are borne throughout society. Defensive medicine, medical practices designed to avert the future possibility of malpractice suits, adds billions of dollars to the cost of health care each year, resulting in higher health insurance premiums for patients and skyrocketing increases in the amount of funding necessary to secure Medicare benefits for our nation's seniors.³

Studies have shown that thousands of patients each year undergo unnecessary testing and treatments, solely because the treating physician has concerns about the medical liability climate in their state. These tests and treatments are done to minimize litigation risks or avoid frivolous lawsuits. A 2006 Harvard School of Public Health study estimated that 28% of all tests and procedures and 13% of all hospitalizations were performed to avoid lawsuits.⁴ Further, a 2003 Department of Health and Human Services (HHS) report estimated that between \$70 and \$126 billion per year was spent on unnecessary tests and procedures, driven in large part by the treating physicians concerns about malpractice liability if these were not carried out.⁵ Additionally, a recent Congressional Budget Office (CBO) analysis concluded that incorporating a comprehensive package of medical liability reform proposals nationwide would result in a 5% reduction in national health care spending. Reduced spending in health care brought about by these proposals would increase federal tax revenues by roughly \$13 billion and reduce federal budget deficits by approximately \$54 billion over the first 10 years. Moreover, mandatory spending for Medicare, Medicaid, the Children's Health Insurance Program and the Federal Employees Health Benefits program would be reduced by approximately \$41 billion over the same period of time. The CBO estimate points to evidence which suggests that Medicare would experience the greatest decline in spending among those programs.⁶ Other reports suggest an even greater degree of cost savings, resulting in decreases in annual health care spending by up to \$200 billion.⁷

The Alliance supports the Commissions call for major changes in the way the Independent Payment Advisory Board (IPAB) is mandated to function. The Alliance supports the Commission's proposal to eliminate "carve-outs" included in the IPAB provisions of the Patient Protection and Affordable Care Act (PPACA).⁸ Under PPACA, the entities responsible for two-thirds of Medicare spending, hospitals, hospices and various other Medicare providers, are exempt from payment cuts until 2019. As stated previously, the Alliance believes that health care cuts have focused disproportionately on physician

³ Berenson R., et al. Center for Studying Health System Change, *Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places* (2003).

⁴ Melo, M. Medical Malpractice: Impact of the Crisis and Affect of State Tort Reforms. The Robert Wood Johnson Foundation. Research Synthesis Report 10. (2006).

⁵ Office of the Assistant Secretary for Planning and Evaluation, U.S. Department Of Health and Human Services. *Dressing the New Health Care Crisis: Reforming the Medical Litigation System To Improve the Quality Of Health Care*. 2003.

⁶ United States Congressional Budget Office. October 2009 Letter.

⁷ McQuillan, L., Abramyan, H. *Pacific Research Institute U.S. Tort Liability Index: 2010 Report*. June 2010.

⁸ Patient Protection and Affordable Care Act, Public Law No. 111-152. 124 STAT. 1029 (2010). Print.

reimbursements. The Alliance also has reservations about the current construction of the IPAB, which lacks the expertise of a single practicing physician or the same level of accountability offered by Congressional action. Currently, the IPAB process mandates adoption of recommendations automatically unless countermanded during an extremely short Congressional and Presidential review period. The Alliance believes such sweeping and important changes in our health care delivery system need to be enacted by an accountable arm of the federal government by an affirmative vote of Congress. The Alliance also has concerns with the process used to approve proposals set forth by this body and as such, commends language in the Commission's report that seems to propose changing the HHS implementation process for IPAB recommendations.

Finally, the Alliance does not agree with the Commission's contention that subsidies for medical education should be dramatically cut. Our nation's system for training physicians is arguably the best in the world and is a magnet for high achievers from across the globe. To the contrary, the Alliance suggests that the federal government should be looking at ways to expand specialist training, given that we face projected shortages of physicians and Medicare beneficiaries are in need of greater access to care, particularly in rural and urban areas. The Association of American Medical Colleges predicts a shortfall of 124,000 physicians by 2025, with the largest portion of that shortage coming from specialty care, both surgical and medical. The proposed cuts will result in decreased patient access to critical health care services, and increase the estimated shortages of 49,000 surgeons/specialists and 46,000 primary care physicians needed to meet predicted demand by 2025.⁹

Again, the Alliance thanks the Commission for their work on this issue and looks forward to working through these difficult issues as the discussion progresses.

Sincerely,

The Alliance of Specialty Medicine

cc: President Barack Obama

cc: Members of the 112th Congress

cc: Bruce Reed
Chief Domestic Policy Adviser to President Clinton

cc: David Cote
Chairman and CEO, Honeywell International

cc: Ann Fudge
Former CEO, Young & Rubicam Brands

cc: Alice Rivlin
Senior Fellow, Brookings Institute and former Director, Office of Management & Budget

⁹ Center for Workforce Studies, Association of American Medical Colleges. *The Complexities of Physician Supply and Demand: Projections Through 2025*. 2008.