



May 12, 2011

The Honorable Dave Camp
Chairman
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Wally Herger
Chair, Health Subcommittee
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Pete Stark
Ranking Member, Health Subcommittee
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Representatives Camp, Levin, Herger, and Stark:

I am writing to you on behalf of AARP's millions of members and the millions of older Americans and their families who depend upon the Medicare program. We applaud the House Ways and Means Committee for holding a hearing on addressing the flawed Sustainable Growth Rate (SGR) system.

As you know, the SGR formula by which Medicare updates its physicians' fees is widely viewed as broken. Yet for more than a decade, Congress has failed to change the system, and the problem continues to grow worse. It has become increasingly more expensive to fix, and the anticipated cuts to doctors continue to grow larger. Unless Congress acts by the end of this year, doctors will see a nearly 30 percent cut in their payments from Medicare. Facing this constant uncertainty and dramatic cuts to their payments, more and more physicians are choosing to no longer take Medicare patients, which impacts beneficiaries' access to care.

Protecting seniors' access to their Medicare doctors is one of AARP's top priorities. We have surveyed our members, and whether they are Democrats, Republicans or Independents, they believe Congress should find a bipartisan, fiscally responsible solution that will keep doctors in the Medicare program. They are concerned that they will lose access to their doctors and future retirees won't be able to get the care they need.

Medicare Physician Payments: Direct Financial Consequences for Beneficiaries

Medicare beneficiaries are directly impacted by the problems associated with the SGR system. Since 1997, Medicare Part B premiums are statutorily set at 25% of Part B program costs. As more is spent on Part B services (such as physician reimbursement), beneficiaries pay more in Part B premiums as well as higher cost-sharing for individual services.

However, for the second year in a row, premiums for most Medicare beneficiaries were not increased for 2011 because current law contains a “hold harmless” provision that protects Medicare beneficiaries who receive Social Security benefits from reductions in their monthly checks when the increase in Part B premiums exceeds that of the Social Security cost-of-living-adjustment (COLA). Because Social Security recipients have received no COLA and their benefit checks have remained the same, the majority of people on Medicare have not experienced a premium increase. However, approximately 25 percent of Medicare beneficiaries – including those assessed a higher income-related premium and those new to the Medicare program – have paid even higher Part B premiums over the past two years to meet the statutory 25% level.

Increased costs to beneficiaries are not limited to premiums. Cost-sharing obligations – which usually reflect 20 percent of Medicare’s payment – also jump each time provider reimbursement rates increase. For each increase of \$10 billion in physician payments, beneficiary coinsurance amounts increase roughly \$2 billion. In addition, the increased Part B spending also leads directly to a higher Part B deductible. Since 2005, the annual deductible has increased along with per capita Part B expenditures.

The Medicare program must be kept affordable. When it was created in 1965, more than half of older Americans were uninsured and they were the population most likely to be living in poverty. Today, the average older person already spends about one third of his/her income on health care. If Part B premiums and cost-sharing continue to escalate, many more beneficiaries will find it increasingly difficult to pay for the care they need.

Private Contracting and/or Balance Billing

Some Members of Congress and provider organizations have recently suggested relaxing “private contracting” and/or “balance billing” rules as a potential solution to the physician payment problem. Under current rules, a physician may enter into a private contracting arrangement with a beneficiary and, in such an arrangement, the beneficiary agrees to pay 100 percent of the physician’s charges for services (under this arrangement, physician charges are typically higher than the Medicare-approved charge for the same service). Some physicians who have private contracting arrangements also charge an additional monthly or annual fee for their services (e.g., concierge medicine). Although such arrangements are possible, Medicare does not cover services provided by physicians who have entered into a private contracting arrangement with Medicare beneficiaries. Physicians who engage in these practices

are barred from participating in Medicare for two years; and those who enter into private contracts must do so for all of their Medicare patients (e.g., they are forbidden from picking and choosing patients and/or services they may bill Medicare).

Under current law, Medicare allows for “balance billing” by non-participating providers; however, the program places a limit on how much non-participating physicians may “balance bill” beneficiaries -- no more than 15 percent of Medicare’s allowed charges. So, for example, nonparticipating physicians are permitted to charge \$115 for services for which Medicare would reimburse only \$100.

The recently introduced Medicare Patient Empowerment Act (H.R. 1700) would relax the Medicare private contracting rules to allow Medicare beneficiaries to contract with their physician outside of Medicare at rates established between the patient and provider. AARP strongly opposes relaxing the current Medicare rules related to balance billing and/or private contracting because they would do nothing more than shift costs onto Medicare beneficiaries. Private contracting and balance billing increase health care costs by raising prices. Seventy-five percent of all health care costs in our country are spent on the treatment of chronic diseases, many of which could be easily prevented with early interventions. Research has shown that when out-of-pocket costs increase, consumers will visit doctors less. These arrangements would only deter beneficiaries from seeking preventive and other care until their illness worsens. Discouraging preventive care will increase the need for more costly treatment and intervention of these chronic diseases, shifting costs to other parts of the Medicare program.

Finally, not only do private contracting and balance billing shift costs onto beneficiaries, but neither do anything to improve the quality of care delivered. In fact, under both approaches, physicians will continue to be rewarded by the quantity of care provided, rather than on the quality of that care. As Congress grapples with how to address the SGR problem, it should focus on rewarding quality providers, not the quantity of services provided.

AARP Encourages Delivery System Reforms

Repeated short-term band-aid approaches for the broken physician payment system is not helpful. Rather, we urge Congress to enact legislation that emphasizes value over volume and improves the quality of care for Medicare beneficiaries.

As you know, the recently enacted Affordable Care Act (ACA) included many delivery system reforms—such as Accountable Care Organizations (ACOs), patient-centered medical homes, value-based purchasing, quality-based payments, and patient safety initiatives. We have been working closely with providers, physicians, and health plans to help ensure that these delivery system reforms can be implemented so that current and future beneficiaries can realize a Medicare program that is both higher quality and more efficient.

For example, AARP believes that ACOs hold the promise of culture change for health care by improving quality, creating better care coordination and service delivery, greater efficiency, and in the long run, lowering costs. We believe that ACOs that meet rigorous performance criteria should share savings with Medicare and be rewarded for higher quality and greater efficiency. Essential protections are needed, however, to ensure that beneficiaries who receive care from clinicians participating in ACOs know their rights and responsibilities and are made aware of the financial incentives inherent in an ACO. We believe that the opportunity for patients to develop trusting relationships with their providers is key to effective patient engagement, which is essential to the success of ACOs.

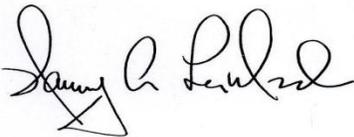
Recently CMS released its proposed rules regarding ACOs and AARP plans to submit formal comments. In general, we are pleased that the proposed rules emphasize a patient-centered approach and contain a strong focus on the three aims of better care, affordable care, and better health for individuals and communities.

It is important to keep in mind, however, that these types of major delivery system reforms take time, planning, and commitment from Congress, the Administration, and providers to achieve a new way of delivering care with new incentives based on achieving quality -- not quantity -- of care. In addition, we believe our nation's leaders must help educate seniors about both planned and proposed changes to the Medicare system. Asking seniors simply to continue to pay more and more to see their doctor can't be the answer.

Conclusion

Over 47 million older and disabled Americans depend on Medicare today. Giving seniors the peace of mind that they can keep seeing their doctors isn't a Republican or Democratic issue. Older Americans agree it's time to work together to find a solution that will keep doctors in Medicare. AARP is committed to working with both sides of the aisle to ensure Congress reaches a financially responsible solution that will ensure seniors have access to the doctors they trust and depend on through the Medicare program.

Sincerely,

A handwritten signature in black ink, appearing to read "Nancy LeaMond". The signature is fluid and cursive, with a large initial "N" and "L".

Nancy LeaMond
Executive Vice President
State and National Group