

**National
Committee to
Preserve
Social Security
and Medicare**



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President &
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**Committee on Energy and Commerce
Subcommittee on Health
“Medicare Physician Payment:
How to Build a More Efficient Payment System”
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National Committee to Preserve Social Security and Medicare
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Mr. Chairman and Members of the Committee:

Thank you for inviting me to participate in this hearing, to present the beneficiary’s point of view in this discussion about physician payment rates.

The National Committee to Preserve Social Security and Medicare is the second largest organization representing seniors in this country. Our 4.6 million members and supporters come from all walks of life and all political backgrounds – what we share in common is our dedication to the preservation of Social Security and Medicare, two of the most successful social insurance programs in our nation’s history.

Mr. Chairman, I am not here today to take a specific position on the various methods of reimbursing physicians participating in the Medicare program. Instead, as an advocate for seniors, I am here to remind this Committee and all Members of Congress that any decision you make relating to the Medicare program has a direct and powerful impact on millions of older Americans.

One of the reasons most seniors choose fee-for-service Medicare over managed care is because most older Americans like their current doctors, and have a strong desire to chose their own doctors. Many seniors have long histories with their family physician, not to mention a host of specialists, and they are loath to start anew with someone who is not extensively familiar with their medical history.

Although there are always cases of closed access, Medicare beneficiaries are generally able to see the doctor of their choice. According to a MedPAC report to Congress on Physician Services in March of this year, 88 percent of Medicare beneficiaries reported that they experienced no problem, or only a small problem, finding a primary care physician. This percentage was the same for privately insured seniors. And while 11 percent of seniors reported significant problems seeing the primary care physician of their choice, the percentage of privately insured patients in the same age category who reported significant problems was higher, at 13 percent.

Specialists were even more available, as 94 percent of Medicare beneficiaries and 91 percent of privately insured individuals reported either no problem, or a small problem, accessing specialists.

The reason access matters is because physicians are often the most important link between Medicare beneficiaries and health care. According to a 2003 CMS study, about 80 percent of non-institutionalized Medicare beneficiaries report that a doctor's office or clinic is their usual source of care. Adequate access to physicians is therefore a key component to keeping seniors healthy.

It should not be a surprise that the threat of losing access to their physicians is one that seniors take very seriously. It is also no surprise that Congress takes this risk equally seriously, as you should. While the Senate has included a "fix" for the physician payment problem in its budget reconciliation bill, the House has not budgeted for this "fix". This seems to be an unrealistic assumption, as Congress has eliminated planned reductions to physicians in all but one earlier fiscal year.

But while we strongly believe doctors should be fairly compensated for their services, I would like to remind you of the flip side of that coin – access can equally be denied if seniors are priced out of the health care market.

Two out of three retirees today receive more than half of their income from Social Security, and for one out of five retirees, Social Security is their only source of income. Social Security is even more important to women. It makes up nearly three-fourths of the income of the average elderly widow, and ninety percent of the income of four out of five widows. This reliance on Social Security is unlikely to change significantly in the future, as only one-half of today's workforce has access to private pensions at work, and the mean 401(k) balance hovers around \$50,000 – hardly enough to finance a lengthy retirement.

Unlike private pensions, most of which do not have cost of living adjustments, Social Security's annual COLA helps seniors keep up with inflation. However, the Social Security COLA can only help so much, because it is based on annual increases in the Consumer Price Index. Medicare premiums, which are set at a level to finance about one-fourth of the cost of Part B, rise significantly faster because they are based on health care inflation. Beneficiaries pay 25 percent of any increase in Part B costs, and that has resulted in dramatic premium increases in recent years.

Since 2000, Medicare Part B premiums have doubled, with increases of 13 percent in 2004, 17 percent in 2005 and 13 percent announced for 2006. In the meantime, Social Security COLAs have lagged far behind, with increases averaging 2.7 percent. If this trend continues, the CMS Office of the Actuary predicts Medicare out-of-pocket costs will consume one-half of the average Social Security benefit by 2021.

If this prediction proves to be accurate, it won't make much of a difference whether physicians are willing to take new Medicare patients or not – many seniors simply won't be able to afford the Part B premiums at all.

That is why any expenditure which will increase Part B costs must be looked at as part of a whole rather than in isolation. The Social Security Office of the Chief Actuary has projected that converting a 4.3 percent reduction in physician payments into a 1 percent increase (as is currently in the Senate reconciliation bill) will result in a premium increase

of \$2.90 in 2007. While this may not seem like a dramatic increase standing alone, when combined with the additional increase already projected by CMS, this represents yet another significant erosion of seniors' standard of living. I would also note that such a provision would merely postpone the problem, as physician payments are scheduled to decrease further in future years.

Although not related directly to physician payments, I would also like to bring to the Committee's attention the impact of managed care plans on traditional fee-for-service Medicare. Managed care plans receive flat benefits per enrollee, rather than receiving compensation based upon specific services rendered. For that reason, regardless of the roadblocks Congress places in their way, they have a natural inclination to recruit younger and healthier seniors. These seniors are the most likely to be familiar with the concept of managed care, and the least likely to have long-standing relationships with specific doctors – this makes them the most receptive to managed care recruitment efforts.

As managed care plans siphon off healthier seniors, the older, less healthy population is left in fee-for-service Medicare, breaking up the risk pool that makes Medicare, as well as all insurance programs, work. A recent MedPAC report found that Medicare pays HMO's an average of 107 percent of what it would pay to cover individuals enrolled in the traditional fee-for-service Medicare program. All Medicare beneficiaries, regardless of whether they enroll in a managed care plan, subsidize these overpayments in the form of higher premiums. In effect, the older, less healthy seniors who are left in traditional Medicare are helping subsidize younger, healthier seniors in managed care.

This drives costs for the fee-for-service program higher, and makes Medicare less accessible to those seniors who need insurance the most – the frailest and most economically vulnerable.

Among MedPAC's recommendations is a proposal to compensate managed care plans at 100% of costs. We believe such an action would remove the most egregious incentive given to managed care plans, and minimize the subsidy participants in traditional fee-for-service provide to those in managed care.

Two final concerns I would like to bring to your attention relate to the Medicare Modernization Act. I know this is not a hearing on the new Part D prescription drug benefit, so I won't digress by discussing that issue, but there is a little known provision in MMA relevant to this hearing that I would like to briefly mention. As you may recall, MMA instituted, for the first time, what is known as a 'soft cap' for the Medicare program. Under this soft cap, if at any point the Social Security Trustees project that the federal contribution to the Medicare program will exceed 45 percent within a seven year window of time, they issue an 'excess general funding' determination in their annual report. If the Trustees issue two such findings in a row, a series of expedited procedures is triggered that requires the President and Congress to consider legislation that would reduce the federal contribution to the program.

I should point out that the expedited procedures do not apply to legislation that would increase payroll taxes, or change the 45 percent threshold, which was an arbitrary limit set without hearings or public input. The expedited procedures only apply to legislation that would cut benefits or increase premiums – either one would result in significant cost shifting from the federal government to seniors.

This year's Trustees report projected the first time the government share would exceed 45 percent in 2012 – just outside the seven year window. Because the cost sharing ratio between beneficiaries and the federal government is 25 to 75 percent, any significant increase in program expenses hastens the day when the 45 percent limit will be reached, and increases the costs that will need to be borne by seniors to bring the federal share back down to the 45 percent limit. Unless increases in health care costs are contained, at some point, Medicare will become unaffordable for all but a few.

Finally, MMA for the first time tied the Medicare Part B deductible to health inflation. In only two years, the deductible has already increased 24 percent, from the flat \$100 per year beneficiaries had paid for years, to \$124 per year announced for 2006 – with further increases expected into the future. This increase affects every senior who is covered by Medicare Part B, whether or not they enroll in the new Part D prescription drug benefit and deserves to be revisited.

To conclude, Mr. Chairman, the National Committee believes in protecting access to health care services for seniors, both financial as well as physical. We urge Congress to keep both in mind as you consider provisions that affect the Medicare program.

Thank you.