

Statement of
M. Todd Williamson, M.D.
on the subject of
“The Need to Move Beyond the SGR”
before the

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

May 5, 2011
10:00 am
2123 Rayburn House Office Building

Executive Summary

The current sustainable growth rate (SGR) physician payment system is failing to serve our nation's seniors and physicians, and as the gap between government-controlled payment rates and the cost of running a practice grows wider, it is increasingly difficult for seniors and the disabled to find doctors who accept new Medicare patients.

The Coalition of State Medical and National Specialty Societies is therefore convinced that the key to preserving our Medicare patients' access to quality medical care is overhauling the flawed Medicare payment system, and to address this problem, Congress should include the Medicare Patient Empowerment Act as an essential part of any Medicare reform. This legislation would:

- Establish a new Medicare payment option whereby patients and physicians would be free to contract for medical care without penalty;
- Allow these patients to apply their Medicare benefits to the physician of their choice and to contract for any amount not covered by Medicare; and
- 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.

Patients and physicians should be free to enter into private payment arrangements without legal interference or penalty. Private contracting is a key principle of American freedom and liberty. It serves as the foundation for the patient-physician relationship, and it has given rise to the best medical care in the world. It should therefore be a viable option within the Medicare payment system.

The day the Medicare Patient Empowerment Act becomes law, **every** physician will become accessible to **every** Medicare patient. Private contracting is a sustainable, patient-centered solution for the Medicare payment system that will ensure our patients have access to the medical care they need.

Introduction

Good morning. My name is Todd Williamson; I am a board-certified neurologist and I treat patients every day in my office in Lawrenceville, Georgia, just northeast of Atlanta.

I would like to express my sincere thanks to Chairman Pitts and the Members of this committee for the opportunity to address the critical issue of Medicare's broken physician payment system.

As background, I had the honor of serving as the president of the Medical Association of Georgia in 2008 and 2009. I currently serve as the spokesman for the Coalition of State Medical and National Specialty Societies, which includes sixteen associations representing some ninety thousand physicians from across the country.

The SGR is Fatally Flawed

Medicare is the nation's largest government-run health care program, and it represents the most glaring example of the need for reform. The current sustainable growth rate (SGR) physician payment system, in particular, is failing to serve our nation's seniors and physicians. Enacted as part of the Balanced Budget Act of 1997, the SGR is a formula utilized by Medicare to limit the growth of physician services. This formula is fatally flawed and is structured in a way that does not appropriately account for the costs of caring for Medicare beneficiaries.

Since 2002, the SGR formula has called for reductions in Medicare reimbursements to physicians. In 2002, physician payments were cut by 5 percent, and since then, Congress has intervened 12 times to prevent additional cuts. Unfortunately, Congress has not yet adopted a permanent solution to fixing the SGR; rather it has passed short-term, stop-gap measures that only temporarily prevent steep payment cuts. Once again, on January 12, 2012, physician payments are scheduled to be cut – this time by 29.5 percent -- and these cuts will continue well into the future.

Medicare's physician payment system is not sustainable for physicians, nor is it fiscally stable for the federal government. The cost of repealing the SGR has now ballooned from just under \$50 billion in 2005 to over \$300 billion today, and the price tag continues to grow each year that Congress puts off permanent reform. Before the costs of reform become financially prohibitive, it is essential that Congress act to reform Medicare's flawed physician payment system in a manner that will also give the government increased budget certainty now and into the future.

Patient Access to Care is at Risk

Existing Medicare underpayments, coupled with the threat of continued steep payment cuts, present serious access to care problems because more and more physicians cannot afford to furnish services to Medicare patients. Baby boomers are now entering the Medicare program, and a shrinking pool of primary care and specialty physicians are making it increasingly difficult for seniors and the disabled to find doctors who accept new Medicare

patients. The American people are well aware of this problem, and according to a survey conducted by the American Medical Association in October 2010, the overwhelming majority – 94 percent – of American adults feel the looming Medicare physician payment cut poses a “serious problem for seniors who rely on Medicare.”

Numerous surveys of our nation’s physicians have also established the Medicare access to care problem.

- A 2008 survey conducted by The Physicians Foundation found that 82 percent of primary care doctors nationwide believed their practices would be “unsustainable” if proposed cuts to Medicare payments were made and nearly half of all primary care doctors were planning to either reduce the number of patients they saw or stop practicing entirely.
- A 2008 survey conducted by the American Medical Association demonstrated that if Medicare payment rates were cut by 10 percent, 60 percent of physicians would limit the number of new Medicare patients they treat, and if payments were cut by 40 percent, 77 percent of physicians would limit the number of new Medicare patients they treat.
- A 2010 survey conducted by the Surgical Coalition found that 29 percent of surgeons would opt out of Medicare, and of those surgeons remaining as Medicare participating physicians, 69 percent would limit the number of Medicare patient appointments and 45 percent would stop providing certain services.

In order to preserve patient choice and timely access to care, the SGR formula must be repealed.

My Medicare, My Choice

As noted above, as the gap between government-controlled payment rates and the cost of running a practice grows wider, physicians are finding it increasingly difficult to accept Medicare patients. The Coalition of State Medical and National Specialty Societies is therefore convinced that the key to preserving our Medicare patients' access to quality medical care is overhauling the flawed Medicare payment system.

To address this problem, our Coalition supports including the Medicare Patient Empowerment Act as an essential part of any Medicare reform. This legislation 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.

Patients and physicians should be free to enter into private payment arrangements without legal interference or penalty. Private contracting is a key principle of American freedom and liberty. It serves as the foundation for the patient-physician relationship, and it has given

rise to the best medical care in the world. It should therefore be a viable option within the Medicare payment system.

Private contracting is also 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 they don'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.

While private contracting would allow physicians to collect their usual full fee in some instances, it would allow them to collect less in others. It is reprehensible for a physician to be subject to civil and criminal penalties if he or she doesn't collect a patient's co-payment, as is now the case. It is irrational for a senior who wants to see a doctor outside the usual Medicare payment system to be forced to forfeit their Medicare benefits. This simply isn't fair to someone who has paid into the Medicare system their entire working life.

The day the Medicare Patient Empowerment Act becomes law, **every** physician will become accessible to **every** Medicare patient. Private contracting is a sustainable, patient-centered solution for the Medicare payment system that will ensure our patients have access to the medical care they need.

In summary, Medicare patients should be free to privately contract with the doctor of their choice without bureaucratic interference or penalty. This will empower individual patients to make their medical care decisions, while providing the federal government with fiscal certainty.

Thank you for the opportunity to comment today.

Members of the Coalition of State Medical and National Specialty Societies

Medical Association of the State of Alabama
Arkansas Medical Society
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
Mississippi State Medical Association
Medical Society of New Jersey
South Carolina Medical Association
Tennessee Medical Association
American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American Society of General Surgeons
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Past Presidents of the American Medical Association

Daniel H. Johnson, Jr., MD
AMA President 1996-1997

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

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

Summary of the “Medicare Patient Empowerment Act”

The “Medicare Patient Empowerment Act” would establish a Medicare payment option for patients and physicians (and practitioners) to freely contract, without penalty, for Medicare fee-for-service services, while allowing Medicare beneficiaries to use their Medicare benefits and allowing physicians to bill the patient for all amounts not covered by Medicare. Physicians and practitioners could continue to elect Medicare participating (PAR) or non-participating (non-PAR) status for other beneficiaries they treat.

Specifically, the proposed bill would:

- Allow Medicare beneficiaries to contract with any physician (or practitioner) outside of Medicare at rates established between the patient and physician or practitioner.
- Allow Medicare beneficiaries to submit claims to the Medicare program.
- Allow the physician or practitioner to file claims on behalf of the beneficiary, and the beneficiary could assign payment to the physician or practitioner regardless of whether the patient or physician (or practitioner) files the claim.
- Require Medicare claims to be paid directly to the beneficiary in the amount that would apply to a Medicare PAR physician or practitioner in the Medicare payment area where the physician or practitioner resides (payments would not be adjusted to reflect any incentive/penalty payments that might otherwise apply to the physician or practitioner relating to the PQRI, electronic prescribing, health information technology or cost-quality payment modifier programs).
- Establish that Medicare balance billing limits would not apply to Medicare charges by the physician or practitioner.
- Specify that if a physician (or practitioner) contracts with a beneficiary, the physician (or practitioner) is not considered a Medicare PAR or non-PAR physician or practitioner, and therefore Medicare requirements do not apply to the physician or practitioner for purposes of services furnished under the contract. (If the physician or practitioner is PAR or non-PAR for other patients, the physician or practitioner would have to comply with Medicare requirements for services furnished to those patients.)
- Establish beneficiary protections, such as (i) requiring a written, signed contract that specifies the physician or practitioner fees before services are furnished and provides that the beneficiary will be held harmless if the physician or practitioner were to bill any amounts in excess of the fees specified in the contract; (ii) prohibiting the contract from being entered in an emergency or urgent care situation; (iii) prohibiting contracts with Medicare and Medicaid dual-eligible individuals; and (iv) indicating in the contract whether the physician or practitioner is excluded from participation under Medicare.
- Define “emergency medical condition” and “urgent health care situation” using existing Medicare definitions for these terms.
- Allow physicians and practitioners to continue as a Medicare PAR or non-PAR physician or practitioner with respect to any patient not covered under the contract.
- Pre-empt state laws that limit balance billing.

DRAFT

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 (Original Signature of Member)

112TH CONGRESS
 1ST SESSION

H. R.

To amend title XVIII of the Social Security Act to establish a Medicare payment option for patients and physicians or practitioners to freely contract, without penalty, for Medicare fee-for-service items and services, while allowing Medicare beneficiaries to use their Medicare benefits.

IN THE HOUSE OF REPRESENTATIVES

Mr. PRICE of Georgia introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to establish a Medicare payment option for patients and physicians or practitioners to freely contract, without penalty, for Medicare fee-for-service items and services, while allowing Medicare beneficiaries to use their Medicare benefits.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicare Patient Em-
 5 powerment Act”.

1 **SEC. 2. GUARANTEEING FREEDOM OF CHOICE AND CON-**
2 **TRACTING FOR PATIENTS.**

3 (a) IN GENERAL.—Section 1802 of the Social Secu-
4 rity Act (42 U.S.C. 1395a) is amended to read as follows:

5 “FREEDOM OF CHOICE AND CONTRACTING BY PATIENT
6 GUARANTEED

7 “SEC. 1802. (a) BASIC FREEDOM OF CHOICE.—Any
8 individual entitled to insurance benefits under this title
9 may obtain health services from any institution, agency,
10 or person qualified to participate under this title if such
11 institution, agency, or person undertakes to provide that
12 individual such services.

13 “(b) FREEDOM TO CONTRACT BY MEDICARE BENE-
14 FICIARIES.—

15 “(1) IN GENERAL.—Subject to the provisions of
16 this subsection, nothing in this title shall prohibit a
17 Medicare beneficiary from entering into a contract
18 with a participating or non-participating physician
19 or practitioner for any item or service covered under
20 this title.

21 “(2) SUBMISSION OF CLAIMS.—Any Medicare
22 beneficiary that enters into a contract under this
23 section shall be permitted to submit a claim for pay-
24 ment under this title, and such payment shall be
25 made in the amount that would otherwise apply
26 under this title if such claim had been filed by a par-

1 ticipating physician or practitioner (as defined in
2 section 1842(i)(2)) in the payment area where the
3 physician or practitioner covered by the contract re-
4 sides. Payment made under this title for any item or
5 service provided under the contract shall not render
6 the physician a participating or non-participating
7 physician, and as such, requirements of this title
8 that may otherwise apply to a participating or non-
9 participating physician would not apply with respect
10 to any items or services furnished under the con-
11 tract.

12 “(3) BENEFICIARY PROTECTIONS.—

13 “(A) IN GENERAL.—Paragraph (1) shall
14 not apply to any contract unless—

15 “(i) the contract is in writing, is
16 signed by the Medicare beneficiary and the
17 physician or practitioner, and establishes
18 all terms of the contract (including specific
19 payment for physicians’ services covered by
20 the contract) before any item or service is
21 provided pursuant to the contract, and the
22 beneficiary shall be held harmless for any
23 subsequent payment charged for a service
24 in excess of the amount established under

1 the contract during the period the contract
2 is in effect;

3 “(ii) the contract contains the items
4 described in subparagraph (B); and

5 “(iii) the contract is not entered into
6 at a time when the Medicare beneficiary is
7 facing an emergency medical condition or
8 urgent health care situation.

9 “(B) ITEMS REQUIRED TO BE INCLUDED
10 IN CONTRACT.—Any contract to provide items
11 and services to which paragraph (1) applies
12 shall clearly indicate to the Medicare beneficiary
13 that by signing such contract the beneficiary—

14 “(i) agrees to be responsible for pay-
15 ment to such physician or practitioner for
16 such items or services under the terms of
17 and amounts established under the con-
18 tract;

19 “(ii) agrees to be responsible for sub-
20 mitting claims under this title to the Sec-
21 retary, and to any other supplemental in-
22 surance plan that may provide supple-
23 mental insurance, for such items or serv-
24 ices furnished under the contract if such
25 items or services are covered by this title,

1 unless otherwise provided in the contract
2 under subparagraph (C)(i); and

3 “(iii) acknowledges that no limits or
4 other payment incentives that may other-
5 wise apply under this title (such as the
6 limits under subsection (g) of section 1848
7 or incentives under subsection (a)(5), (m),
8 (q), and (p) of such section) shall apply to
9 amounts that may be charged, or paid to
10 a beneficiary for, such items or services.

11 Such contract shall also clearly indicate whether
12 the physician or practitioner is excluded from
13 participation under the Medicare program
14 under section 1128.

15 “(C) BENEFICIARY ELECTIONS UNDER
16 THE CONTRACT.—Any Medicare beneficiary
17 that enters into a contract under this section
18 may elect to negotiate, as a term of the con-
19 tract, a provision under which—

20 “(i) the physician or practitioner shall
21 file claims on behalf of the beneficiary with
22 the Secretary and any supplemental insur-
23 ance plan for items or services furnished
24 under the contract if such items or services

1 are covered under this title or under the
2 plan; and

3 “(ii) the beneficiary assigns payment
4 to the physician for any claims filed by, or
5 on behalf of, the beneficiary with the Sec-
6 retary and any supplemental insurance
7 plan for items or services furnished under
8 the contract.

9 “(D) EXCLUSION OF DUAL ELIGIBLE INDIVIDUALS.—Paragraph (1) shall not apply to
10 any contract if a beneficiary who is a eligible
11 for medical assistance under title XIX is a
12 party to the contract.

13
14 “(4) LIMITATION ON ACTUAL CHARGE AND
15 CLAIM SUBMISSION REQUIREMENT NOT APPLICABLE.—Section 1848(g) shall not apply with respect
16 to any item or service provided to a Medicare bene-
17 ficiary under a contract described in paragraph (1).

18
19 “(5) CONSTRUCTION.—Nothing in this section
20 shall be construed to prohibit any physician or prac-
21 titioner from maintaining an election and acting as
22 a participating or non-participating physician or
23 practitioner with respect to any patient not covered
24 under a contract established under this section.

25 “(6) DEFINITIONS.—In this subsection:

1 “(A) MEDICARE BENEFICIARY.—The term
2 ‘Medicare beneficiary’ means an individual who
3 is entitled to benefits under part A or enrolled
4 under part B.

5 “(B) PHYSICIAN.—The term ‘physician’
6 has the meaning given such term by paragraphs
7 (1), (2), (3), and (4) of section 1861(r).

8 “(C) PRACTITIONER.—The term ‘practi-
9 tioner’ means a practitioner described in section
10 1842(b)(18)(C).

11 “(D) EMERGENCY MEDICAL CONDITION.—
12 The term ‘emergency medical condition’ means
13 a medical condition manifesting itself by acute
14 symptoms of sufficient severity (including se-
15 vere pain) such that a prudent layperson, with
16 an average knowledge of health and medicine,
17 could reasonably expect the absence of imme-
18 diate medical attention to result in—

19 “(i) serious jeopardy to the health of
20 the individual or, in the case of a pregnant
21 woman, the health of the woman or her
22 unborn child;

23 “(ii) serious impairment to bodily
24 functions; or

1 “(iii) serious dysfunction of any bodily
2 organ or part.

3 “(E) URGENT HEALTH CARE SITUA-
4 TION.—The term ‘urgent health care situation’
5 means services furnished to an individual who
6 requires services to be furnished within 12
7 hours in order to avoid the likely onset of an
8 emergency medical condition.”.

9 **SEC. 3. PREEMPTION OF STATE LAWS LIMITING CHARGES**
10 **FOR PHYSICIAN AND PRACTITIONER SERV-**
11 **ICES.**

12 (a) IN GENERAL.—No State may impose a limit on
13 the amount of charges for services, furnished by a physi-
14 cian or practitioner, for which payment is made under sec-
15 tion 1848 of the Social Security Act (42 U.S.C. 1395w–
16 4), and any such limit is hereby preempted.

17 (b) STATE.—In this section, the term “State” in-
18 cludes the District of Columbia, Puerto Rico, the Virgin
19 Islands, Guam, and American Samoa.