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June 4, 2012

The Honorable Tom Coburn
U.S. Senate
Washington, DC 20510

Subject: Seniors' Choice Act

Dear Senator Coburn,

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing 4,000 practicing neurosurgeons in the United States, we are pleased to support your bill, the Seniors' Choice Act. As you know, the current Medicare program is clearly on an unsustainable path. With an aging population and rising healthcare costs, it is therefore imperative that Congress take immediate action and adopt meaningful reforms. This legislation is a common-sense approach to modernizing and improving Medicare and will help ensure that our nation's senior citizens continue to benefit from this critical entitlement program well into the future.

We are particularly pleased to see that your legislation addresses the following issues:

- ***Improves Medicare Out-of-Pocket Limits and Cost Sharing.*** One way to ensure that the Medicare program remains a viable benefit for the country's senior and disability population is to modernize and improve the patient cost-sharing component. Your legislation would accomplish this in a number of ways including modifications to the current deductibles, co-payments and out-of-pocket limits. Importantly, it recognizes that it is reasonable for wealthier beneficiaries to contribute more to the system, while at the same time protecting the most economically vulnerable from significant out-of-pocket exposure. Finally, it aligns the Medicare and Social Security eligibility ages.

- ***Eliminates the Independent Payment Advisory Board***. Established by the Patient Protection and Affordable Care Act (PPACA), the Independent Payment Advisory Board (IPAB) is a 15-member government board appointed by the president. The principal responsibility of this board is to cut Medicare spending, and the proposed spending cuts automatically go into effect if Congress does not replace the recommendations with cuts of equal magnitude. Congress only has a very short window of time in which to pass its own proposal -- making it a virtual certainty that the board's recommendations would be adopted. The AANS and CNS are certainly mindful of the need to curb Medicare spending, but we believe that leaving Medicare policy decisions in the hands of an unelected, unaccountable governmental body, with minimal congressional oversight and no judicial review, will negatively affect timely access to quality neurosurgical care.

- ***Provides a Bridge to a New Medicare System.*** The Medicare program is only as strong as its component parts, and without an adequate physician workforce, the system will fail to meet the

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needs of our aging population. There are a number of considerations that we would like to raise in this regard.

- One critical factor that is causing more and more physicians to reconsider their participation in Medicare is the flawed sustainable growth rate (SGR) system. As you are well aware, this is an issue that has plagued physicians and their patients for more than a decade, and the AANS and CNS appreciate that your legislation would prevent the draconian pay cuts that physicians face in the upcoming years – beginning with a cut of nearly 30 percent on January 1, 2013. Providing this payment stability will certainly help us "bridge" to a new Medicare system.

- Despite efforts to provide payment stability under the SGR system in your bill, practice expense costs will continue to outpace payment rates. The AANS and CNS, therefore, also suggest that you consider an additional patient-centered solution for reforming the Medicare payment system -- allowing Medicare beneficiaries and physicians to privately contract for Medicare covered services without penalty. The Medicare Patient Empowerment Act (S. 1042) incorporates this model, which would allow beneficiaries to use their Medicare benefit to offset a portion of the contracted fee and would not require physicians to "opt out" of the Medicare program for two full years.

- We also take issue with the notion that fee-for-service medicine is the root of all healthcare evils. Many physicians may not want or be able to participate in alternative delivery system/ payment models, so it is imperative that a viable fee-for-service option remain in place. While it may not be perfect, fee-for-service is not the sole contributor to the problems with the current Medicare physician payment system.[1] To the contrary, fee-for-service provides patients with the ability to select the physician or other healthcare provider of his or her choice, and preserving this option for Medicare beneficiaries is especially critical for those patients seeking specialty care – particularly neurosurgical services. While your legislation does not technically abolish Medicare fee-for-service, we encourage you to take steps to ensure its viability as an option in any new or transitional Medicare system.

- Organized neurosurgery is fully behind efforts to improve the quality of care that neurosurgeons deliver to our patients and we share with the public a sense of urgency and responsibility to meet the challenges of creating a sustainable healthcare system. And while Congress has taken the first steps towards implementing quality improvement programs, the PQRS, EHR program and value-based payment modifier all need to be scrapped or drastically revised to better incorporate a workable and meaningful system for collecting and reporting clinical data. The current "one-size-fits-all" approach simply will not result in better patient outcomes. It is not clear whether or not your legislation would retain these programs or if under your premium support model you would repeal these initiatives. If you intend to maintain them (or some similar version), the AANS and CNS recommend you incorporate a pay-for-*participation* system under which data regarding physician quality are collected in a non-punitive environment and analyzed using accurate risk-adjustment mechanisms. Under such a system, physicians should receive performance feedback continually and in a timely manner.

  To this end, neurosurgery has developed a centralized and nationally coordinated effort to allow individual neurosurgeons and practice groups to measure and analyze practice patterns

[1] National Center for Policy Analysis, John Goodman Health Policy Blog, "Is Fee-For-Service the Problem?" March 28, 2012. Scandlen, Greg. http://bit.ly/HlTwAr

and outcomes. This unprecedented quality care program, The National Neurosurgery Quality and Outcomes Database (N^2QOD), will allow any U.S. neurosurgeon, orthopedic spine specialist, practice group, or hospital system to contribute to and access national aggregate quality and outcomes data. The N^2QOD is primarily designed to serve as a continuous national clinical registry for neurosurgical procedures and practice patterns along the lines of the very successful Society of Thoracic Surgeons' database. Any Medicare reimbursement system that is based on quality should be structured around specialty society clinical outcomes databases, which is a much more meaningful way of improving the value of healthcare than the current government and private sector-sponsored programs.

- ***Breaks Down the Medicare Silos.*** Unquestionably, for nearly half a century, the Medicare program has provided exceptional healthcare for the elderly. Your bill rightly recognizes, however, that simply making changes to the current Medicare payment system, without incorporating larger programmatic changes, is like rearranging the deck chairs on the Titanic. From a structural point, the current "silos" are a significant contributing factor to today's antiquated Medicare program. Medicare's separate Parts A, B, C and D do not reflect the modern realities of practice, including, in particular, shifts in the site-of-service. For example, many procedures that were once done in the hospital inpatient setting (Part A), are now performed in a Part B, ambulatory setting (e.g., ambulatory surgery center or physician office), although the separate programmatic dollar streams have not changed. While your legislation would leave the Part D prescription drug benefit as a separate, stand-alone program (with an additional premium structure), it is clear that today's Medicare beneficiary views his or her Part A and B benefits as a single insurance program.

  The AANS and CNS agree that we need to move from Medicare's current defined benefit structure to a defined contribution model like the one outlined in your legislation. Like the Federal Employee Health Benefit Program (FEHBP), this bipartisan premium support model would pay Medicare beneficiaries a defined sum toward the purchase of an insurance policy that provides a defined set of services. Seniors would then pick from an array of health plan choices, allowing them to choose the plan that works best for them. Importantly, your legislation contains essential consumer protections, but it is equally critical that the premium subsidies are adequate to provide beneficiaries with appropriate coverage for their medical needs. To this end, we are pleased to see that your bill recognizes the need to risk-adjust the premium subsidy so that the sickest beneficiaries are not unfairly penalized because of their health status. While we are not in a position to determine the actuarial data, we support the concept that lower-income seniors should receive a higher federal subsidy than wealthier seniors. Finally, it is important that all current Medicare beneficiaries are allowed to remain in the existing Medicare program, if they so choose.

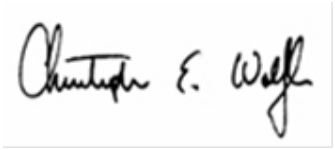
- ***Preserves Medicare Funding for GME***. An appropriate supply of well-educated and trained physicians is an essential element to ensure access to quality healthcare services for all Americans. Unfortunately, the nation is facing a serious shortage of physicians, particularly as baby boomers age. According to the Association of American Medical Colleges, by the year 2025, there will be an overall shortage of 130,600 physicians -- roughly half (65,800) of the shortage will be in primary care and the other half (64,800) surgeons and other procedural specialists.[2] While medical schools in the U.S. have increased their enrollments, and additional medical and osteopathic schools have been established, the number of Medicare-funded residencies has been capped by law at 1996 levels. The solution for increasing physician

[2] Association of American Medical Colleges, Center for Workforce Studies, "The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025" June 2010. http://bit.ly/hC24Q7

numbers involves not only increasing medical student class size and the number of medical schools, but also increasing the number of funded residency positions. The AANS and CNS believe that since all Americans benefit from a strong supply of physicians, all payers of healthcare – including the federal government, the states and private payers – should help fund graduate medical education. To ensure an adequate supply of physicians, Congress should, therefore, at a minimum, maintain Medicare's current financial support of graduate medical education.

Thank you for considering our comments and recommendations. We look forward to working with you on this and other important health policy issues. If you need further information or have any questions, please don't hesitate to contact us.

Sincerely,



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