



AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

**STATEMENT OF THE
AMERICAN COLLEGE OF PHYSICIANS –
AMERICAN SOCIETY OF
INTERNAL MEDICINE
TO THE COMMITTEE ON FINANCE
For the Record of the
Hearing on The Bush Proposal for Medicare Modernization
March 7, 2002**

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) – representing 115,000 physicians and medical students – is the largest medical specialty society and the second largest medical organization in the United States. Internists provide care for more Medicare patients than any other medical specialty. We congratulate the Committee on Finance for holding this important hearing to address President George W. Bush’s proposals for Medicare modernization. ACP-ASIM thanks Senator Max Baucus, chair of the Committee, Senator Charles E. Grassley, the ranking member of the Committee, and other committee members for convening this important hearing.

President Bush’s Fiscal Year 2003 budget proposes many important first steps in reforming the Medicare program. The budget proposed to spend \$190 billion over ten years for improving the Medicare program. A prescription drug program would receive \$77 billion to help states cover prescription drugs for Medicare beneficiaries between 100 and 150 percent of poverty. The remaining \$113 billion would be used to overhaul the Medicare plan and provide a universal drug benefit.

ACP-ASIM is pleased that the budget summary acknowledges the problems caused by constant changes in Medicare physician payments and expresses the administration’s willingness to work with Congress to fix the problem, both short and long term. However, we are concerned that the President’s budget does not provide any relief for teaching hospitals from scheduled budget cuts. Instead, the budget proposed further unspecified cuts of \$570 million over ten years in Medicare funding for the indirect costs of graduate medical education.

Background

Medicare’s enduring success as a program has been predicated on its promise of coverage for all elderly and disabled persons, regardless of income. Because virtually all Americans anticipate that they will someday be eligible for Medicare, the program has enjoyed sustained political support from voters. Such support has proven to be a critical factor in assuring a sufficient commitment of funds from Congress to finance the program.

Medicare's success has also been a function of the unparalleled choice and availability of physicians and health care services that it offers beneficiaries. Today, most private sector health insurance plans restrict enrollees to a pre-selected panel of providers. By contrast, under the traditional fee-for-service program, Medicare patients are permitted to obtain care from any health care provider who is willing to see them. (Even beneficiaries who opt to enroll in Medicare+Choice managed care plans have had the ability to rejoin the fee-for-service program, with its virtually unlimited choice of physicians, anytime during a calendar year). Participation of physicians and other health care providers in the traditional Medicare fee-for-service program historically has been extraordinarily high, due in large part to reimbursement rates that made it economically attractive for them to participate in the program.

By contrast, the Medicaid program - the sister program created by Congress in 1965 to provide access to care for poorer Americans - has fared far less when compared to Medicare. As a means-tested program, it has not had the broad political support needed to sustain its financing. Low Medicaid reimbursement rates have led to low levels of participation by physicians and other providers. Medicaid patients typically have far less choice of physicians and other health care providers than Medicare beneficiaries. The research literature on Medicaid is rife with evidence on the difficulties encountered by enrollees in accessing needed care.

Unfortunately, there is reason to believe that Medicare is becoming more like Medicaid. *In the absence of legislation to reform the program, Medicare is on the verge of becoming a chronically under-funded program, one which offers limited choice of providers and reduced access.*

Medicare also faces other threats. *It has suffered from a program management mindset that emphasizes micromanagement and sanctions over innovation and collaboration.* Excessive regulation diverts resources from patient care, drives up the compliance costs incurred by health care professionals, and discourages provider participation in the program. *Medicare's outdated benefit structure excludes coverage for essential life-saving medications and preventive/screening services. Medicare's financing structure, which relies on payroll taxes, premium contributions and general revenue, is likely to be inadequate to assure continued access to care, particularly as the "baby boom" generation becomes Medicare-eligible and the costs of care continue to rise.*

Over the past several years, ACP-ASIM has developed a series of position papers that diagnose Medicare's ills - inadequate reimbursement for existing services, excessive regulation, outdated benefits, and a financing structure that will be insufficient to meet the challenges of an aging population and rising health care costs. Based on those position papers, America's internists today are proposing a plan of treatment to cure Medicare's ills. Further explanation of the College's diagnoses and policy prescriptions can be found in the more detailed position papers.

Medicare Reimbursement to Physicians and Teaching Hospitals

Medicare suffers from declining reimbursement rates that threaten patients' access to care.

Beginning January 1, 2002, Medicare reimbursement payments to physicians and other health care professionals fell an average of 5.4 percent. The Centers for Medicare and Medicaid Services (CMS) projects that payments for physician services will continue to decline for at least the next three years.

As illustrated in the attached chart, Medicare payments will continue to fall behind the increased costs of delivering services over the 2002-2005 calendar period:

- 2002: On January 1, Medicare payments for physician services were cut by 5.4 percent before inflation; 8.2 percent after inflation*.
- 2003: Medicare payments for physician services are projected to be cut by 10.8 percent before inflation and 16.2 percent after inflation* (relative to 2001).
- 2004: Medicare payments for physician services are projected to be cut by 15.9 percent before inflation and 23.5 percent after inflation* (relative to 2001).



AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

- 2005: Medicare payments for physician services are projected to be cut by 18.3 percent before inflation and 28.1 percent after inflation* (relative to 2001).

*Note: The above assumes a very conservative annual inflation rate in the costs of providing services of 3 percent per year over the 2002-2005 period. Actual inflation increases in the costs of providing services are likely to be higher. Therefore, the above estimates likely *understate* the magnitude of the anticipated cuts after increases in the costs of providing services are taken into account.

The problem of payment reductions that are falling below increases in the costs of providing services is not one that was created overnight. Congress adopted the current physician payment methodology for updating annual payments (known as the Sustainable Growth Rate or SGR) in the Balanced Budget Act of 1997. Even then, ACP-ASIM recognized the serious flaws inherent in the SGR payment system and voiced our concern. Congress attempted to make corrections to the payment formula in 1999 with the Balanced Budget Refinement Act; however, it was not sufficient enough to correct the intrinsic problems. The economic downturn the country is now facing has only exacerbated the problem.

The SGR system errantly ties physician payment to the Gross Domestic Product (GDP). There is no other segment of the health care industry that uses such a methodology to update payment. This method of tying physician payment to the health of the overall economy bears absolutely no relation to the cost of providing actual physician services. In the years where the economy is facing a downturn, such as today, massive cuts in payments for physician services' can be triggered.

In its March 2002 report to the Congress, the Medicare Payment Advisory Commission (MedPAC) expresses grave concern about the underlying problem of tying the SGR to the economy. MedPAC states that the current SGR system may even cause payments to deviate from physician costs because it does not fully account for factors affecting the actual cost of providing services, and recommends that Congress replace the SGR with a new framework, based on input prices for physician services adjusted for productivity gains.

Physicians have a strong sense of commitment to their Medicare patients. They will do everything within reason to continue to provide their Medicare patients with high quality, accessible health care, even in the face of rising costs and declining reimbursement. *However, there is a point where the economics of running a practice will force physicians to institute changes to limit the damage from continued Medicare payment cuts.* Like any small business, revenue must exceed the costs of providing services in order for a practice to remain financially viable. Physicians will have essentially only four options available to them to offset the losses from declining Medicare payments and rising costs. They can reduce their reliance on Medicare revenue, by restructuring their practices to decrease the share of their practice revenue that comes from Medicare, while increasing the share that comes from more reliable (non-Medicare) payers. This would be accomplished by putting limits on how many Medicare patients will be seen while marketing the practice to non-Medicare populations. They can cut costs - eliminating beneficial services and technology. They can do both: cut beneficial services *and* reduce their reliance on Medicare. Or they can go out of business, by closing their practices entirely.

Physician services are not the only provider area that has been subjected to deep Medicare payment cuts. Teaching hospitals, home health agencies, hospitals, and other providers are also facing cuts. Under-funding of these other Medicare benefits also poses a long-term threat to the program. No other area of provider reimbursement, however, will be cut by almost 30 percent (in constant 2001 dollars) over the 2002-2005 period. Therefore, the highest priority should go toward halting the cuts in payments for physician services and, secondly, averting continued cuts in payments for key "safety net" providers, particularly teaching hospitals that provide a large proportion of indigent care.

Congress should assure that payments are sufficient to assure continued access to existing Medicare benefits. Specifically:

1. Congress should halt the 5.4% cut in 2002 payments for physician services
2. Congress should enact MedPAC's recommendation to eliminate the SGR and replace it with an update framework based on changes in physicians' input prices, with adjustments for productivity and other factors that affect the cost of, and access to, care.
3. Congress should also include a default formula to establish the update, based on the Medicare economic index (MEI) minus a .5% productivity adjustment, in years when Congress chooses not to act to establish an update based on the MedPAC update recommendation.
4. Congress should also set the CY 2003 update at the MEI minus a .5% adjustment factor. (This change is necessary to assure that payments next year keep pace with increased costs, as the new MedPAC framework is being implemented).
5. Congress should halt further reductions in indirect medical education payments to teaching hospitals.

Reducing Regulatory Burdens

Medicare suffers from a management approach that has emphasized excessive regulation and paperwork, rather than strategies that encourage innovations in service delivery to lower costs and enhance quality of care.

The Medicare program has historically relied on audits, documentation, and complex payment rules to control costs. It is impossible for physicians to keep abreast of the vast, ever expanding and ever changing array of Medicare rules, regulations, instructions, and policies - an estimated 100,000 pages of Medicare requirements. This information is disseminated from many sources and is often difficult to accurately comprehend and interpret. The emphasis on excessive documentation, micromanagement and audits diverts physicians' attention away from patient care. Unfunded regulatory mandates, coupled with declining fees, may force physicians to re-assess their relationship with Medicare, and thereby, limit their services currently provided for Medicare patients.

Fortunately, progress is being made in easing Medicare hassles and red tape. The House of Representatives unanimously passed a Medicare reform bill in December 2001 that would limit the use of extrapolation (the ability of auditors to examine as few as fifteen records and apply the results to thousands of claims); require Medicare carriers to provide written clarification when requested; require payers to honor those clarifications during audits; require that independent contractor review of denials of services take place before a carrier could demand repayment for services; and use pilot projects to determine alternative ways of documenting evaluation and management (E/M) services. The Department of Health and Human Services has also appointed a new advisory committee on regulatory relief to solicit proposals on changes that the department can make on its own to reduce red tape.

Easing excessive Medicare red tape is not enough, however. The Centers for Medicare and Medicaid Services (CMS) needs to be directed to use innovative approaches to delivering, paying for, and purchasing services that have the potential of reducing costs and improving quality. In a 1997 position paper, ACP-ASIM recommended that Medicare needed to undergo a realignment that would focus on encouraging a more coordinated and comprehensive approach to providing care to Medicare beneficiaries with chronic illnesses. It proposed changes in Medicare payment policies (e.g. expanded bundled payment, contracting with providers for care management and coordinated care of chronic patients, and competitive bidding) and the inclusion of additional covered services



AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

(e.g. case management, expanded hospice-type services, and preventive care). The Lewin Group estimated at that time that such changes could save \$65 billion over five years. Potential savings today from such methods would need to be recalculated to reflect changes in the program and new budget baseline projections from the Congressional Budget Office; however, the 1997 data suggest that substantial savings from the recommended changes are possible. Although Congress and the Medicare program have instituted some demonstration projects and program innovations that are consistent with the 1997 proposals from ACP-ASIM, more needs to be done to encourage Medicare to support innovative methods of delivering and paying for medical care and to use its prudent purchasing authority to reduce costs.

Congress and CMS should realign Medicare's management philosophy from one that emphasizes regulation and micromanagement to one that encourages innovation in health care delivery. Specifically:

1. Congress should enact H.R. 3391, the Medicare Regulatory and Contracting Reform Act of 2001.
2. HHS Secretary Thompson's advisory committee on regulatory relief should continue to work with physicians and other health care professionals to institute changes to reduce specific unnecessary regulatory requirements. The task force's emphasis should be expanded to address ways to achieve long-term changes in how CMS approaches the regulatory process, such as by requiring that CMS regularly assess the amount of *time* required by health care providers in complying with regulations in addition to the direct costs of compliance.
3. CMS should be directed, and given the authority to, support innovative programs for health care delivery, including expanded use of case management, disease management, and coordinated services for patients with chronic conditions, bundled payment for selected services, and expanded hospice-like services to terminally ill patients who otherwise would not qualify for hospice benefits.
4. CMS should be directed to use competitive bidding, negotiations, and other prudent purchasing methods to lower prices for equipment and supplies.

Prescription Drug Coverage and Modernization

Medicare suffers from an outdated benefits package that denies patients access to life-saving medications and preventive/screening services and exposes beneficiaries to catastrophically high out-of-pocket expenses.

Medicare beneficiaries are denied access to important life-saving medical services because the existing plan of benefits, which remains fundamentally the same as that which was established when the program was created in 1965, excludes coverage for most prescription drugs and preventive and screening tests. Although Congress has added some preventive services, such as coverage for selected cancer screening tests on a piecemeal basis, the basic requirement for coverage is that the service must be for the *diagnosis and treatment of disease on patients who present themselves with symptoms of disease*. Screening tests on well beneficiaries generally are not covered benefits.

Medicare benefits must be updated to cover needed medications and preventive care. However, the addition of Medicare benefits for preventive services should be based upon evidence of medical effectiveness. The cost-sharing structure also needs to be modified to reduce inequities and to encourage prevention. Currently, cost-sharing for hospital admissions is much higher than for those seeking out-patient physician care. Once a package of preventive and screening procedures is added to Medicare, it will be important to exempt such services from cost-sharing requirements that otherwise would create an economic barrier to obtaining such services. There is no limit on total out-of-pocket expenses that may be incurred by a patient in a calendar year or lifetime. These issues put the Medicare program and its beneficiaries at risk—for poor health and financial disaster.

Ideally, a prescription drug benefit should cover all Medicare beneficiaries equally. However, if a universal benefit carries too large a price tag, then coverage should be targeted to those most in need—low-income beneficiaries, those with high drug costs, and those with multiple chronic diseases. To ensure a high quality of life and to eliminate costly, unnecessary hospitalizations, our most vulnerable Medicare beneficiaries must have access to needed prescription medications.

ACP-ASIM supports a number of mechanisms to control the costs of a prescription drug benefit, but with the conditions that patient safety and quality of care should be the primary focus

Congress should expand Medicare benefits to cover prescription drugs, institute measures to lower the costs of prescription drugs, provide coverage for evidence-based preventive and screening procedures, and modify Medicare's cost-sharing structure to better meet the needs of beneficiaries.

Prescription Drug Coverage

1. The highest priority should go toward providing voluntary prescription drug benefits for those most in need: low income beneficiaries who do not have access to drug coverage under other plans.
2. If sustainable, predictable financing is available, ACP-ASIM supports providing an optional Medicare prescription drug benefit to all beneficiaries, regardless of income and health status.
3. Drug benefit plans should be voluntary, and seniors should be able to opt out of the program and maintain their existing Medicare coverage.
4. The benefit must be financed in such a way as to bring in sufficient revenue to support the costs of the program, both short and long-term, without further threatening the solvency of the Medicare program or requiring cuts in payments for other services or reduced benefits in other areas. ACP-ASIM recommends that Congress consider: (1) increasing general revenues or payroll taxes to support a Medicare prescription drug benefit, and (2) income-related premium contributions, co-payments, and deductibles to support the program.
5. The maximum allowable Medicare reimbursement for prescription drugs should balance the need to restrain the cost of the benefit with the need to create financial incentives for manufacturers to continue to develop new products.
6. Rigid price controls that will discourage innovation and threaten drug supply should be rejected.
7. ACP-ASIM supports using prudent-purchasing tools in designing a Medicare prescription drug benefit. Like the VA, Medicare should investigate average wholesale drug prices and directly negotiate with manufacturers or wholesalers.
8. Until the safety concerns issued by the FDA and HHS are resolved, ACP-ASIM opposes prescription drug re-importation as a means to reduce retail drug prices.
9. If therapeutic safety and equivalency are established, then generic drugs should be used, as available, for beneficiaries of a Medicare prescription drug benefit. In order to eliminate delays for generic entry into the market and discourage financial arrangements between generic and name brand manufacturers, Congress should close loopholes in patent protection legislation.
10. ACP-ASIM supports research into the use of evidence-based formularies with a tiered co-payment system and a national drug information system, as a means to safely and effectively reduce the cost of a Medicare

prescription drug benefit, while assuring access to needed medications. Demonstration projects to test such methods should be established before a national program is introduced

11. Medicare prescription drug formularies should not operate to the detriment of patients, such as those developed primarily to control costs. Decisions about which drugs are chosen for formulary inclusion should be based on effectiveness, safety, and ease of administration rather than solely based on cost.
12. Formularies should be constructed so that physicians have the option of prescribing drugs that are not on the formulary (based on objective data to support a justifiable, medically-indicated cause) without cumbersome prior authorization requirements.
13. Medicare prescription drug benefit should not limit coverage to certain therapeutic categories of drugs, or drugs for certain diseases.
 - a. To counterbalance pharmaceutical manufacturers' direct-to-consumer advertising, ACP-ASIM recommends that insurers, patients and physicians have access to unit price and course of treatment costs for medically equivalent prescription drugs.
14. If pharmacy benefit managers (PBMs) are used to administer a Medicare prescription drug benefit, they should be subject to consumer protection standards of accountability, including:
 - Disclosure to patients, physicians, and insurers of the financial relationships between PBMs, pharmacists, and pharmaceutical manufacturers;
 - Requiring that PBM requests to alter medication regimes occur only when such requests are based on objective data supported by peer reviewed medical literature and after having undergone review and approval by associated MCO/MBHO Pharmacy and Therapeutics Committees,
 - Requiring that, with a patient's consent, PBMs be required to provide treating physicians with all available information about the patient's medication history.
15. ACP-ASIM believes that switching prescription medications to over-the-counter status should be based on clear clinical evidence that an OTC switch would not harm patient safety, through inaccurate self-diagnosis and self-medication, or lead to reduced access to "switched" drugs because they would no longer be covered under a prescription drug benefit. Manufacturers and other interested parties should be allowed to request such a reclassification.
16. ACP-ASIM supports the creation of a Medicare prescription drug card program as a first step to providing seniors assistance with prescription drug costs, provided that:
 - The program is not a substitute for comprehensive Medicare prescription drug coverage.
 - Pharmacy benefit managers (PBMs) are required to pass on rebates from manufacturers to pharmacies, and subsequently, beneficiaries.
 - Program costs for beneficiaries are minimal or free.
 - Card sponsors publish complete drug pricing information, so that Medicare recipients can "shop" for the best card

Evidence-based Preventive and Screening Services

17. Congress should establish a process to authorize coverage of appropriate and cost-effective preventive care and screening services in an ongoing fashion, based on expert evaluation of, and consensus on, the medical evidence of their effectiveness. Medicare payment levels to physicians for covered preventive benefits must be adequate to assure that beneficiaries have access to such services.
18. Congress should authorize coverage for physician-directed geriatric assessments and care coordination of frail elderly patients, as defined in S. 775, the Geriatric Care Act of 2001.

Cost-Sharing Requirements and Stop-Loss Coverage

19. Congress should establish a total annual and lifetime limit on out-of-pocket expenses under Medicare for all covered services.
 - a) Congress should consider combining Medicare Parts A and B with a single deductible, provided that:
 - b) Medicare benefits are expanded to include coverage of preventive and screening procedures, and geriatric care assessments;
 - c) Such specified preventive and screening procedures are not subject to the deductible, and no co-insurance or co-payments would apply;
 - d) A limit is placed on total out-of-pocket expenses that a beneficiary may incur in a calendar year (i.e., stop-loss coverage);
 - e) The single deductible is set at an actuarially appropriate level that does not cause an undue financial burden on beneficiaries, especially lower-income beneficiaries.

Medicare Program Solvency

Medicare suffers from a financing structure that may not be adequate to assure continued solvency as the population ages and as medical care costs continue to rise. Some proposals to fundamentally change the program, however, would unacceptably weaken key strengths of the existing program (i.e., “the cure would be worse than the sickness”).

The changes outlined in the previous parts of this statement will help lower costs and improve the quality of patient care. However, additional changes in Medicare financing may be required to assure the continued solvency of the program.

One option is to convert Medicare to a defined *contribution* program. Under a defined contribution program, the federal government would provide each beneficiary with an allowance to purchase a package of benefits in the private sector. The amount of the allowance could be linked to the cost of a package that includes benefits comparable to the current Medicare program, but this would not be guaranteed. Another variation of this approach is a defined *benefit* voucher program. Like a defined contribution, a premium support program would provide beneficiaries with an allowance to purchase coverage in the private sector, but with a *requirement* that the voucher be sufficient to purchase coverage equal to the current Medicare program.

Critics of a defined contribution program argue that it would erode benefits for lower-income beneficiaries, because the federal allowance would be too low for them to afford a plan with comprehensive benefits comparable to the current program. As an alternative, they propose maintaining the current Medicare benefit structure, with increased taxes if necessary to assure continued solvency.



AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

The College has strong practical and philosophical objections to converting Medicare to a defined contribution program. ACP-ASIM has a long-standing history of support for universal coverage. While the Congress has been unable to agree on a program to provide coverage to all Americans, the existence of Medicare has provided coverage for *all elderly and disabled* Americans. A defined contribution program would price many lower-income elderly and disabled Americans out of the market for coverage. It would therefore represent a set back in the drive to expand coverage to all Americans. On this basis alone, as a matter of principle, ACP-ASIM cannot support conversion of Medicare into a defined contribution program.

ACP-ASIM is particularly concerned about the impact a defined contribution program would have on less wealthy beneficiaries. One of the abiding strengths of the conventional Medicare program is that it provides the same coverage and benefits to beneficiaries, regardless of income or acquired assets. The fact that Medicare is not viewed as a "welfare" program is one of the reasons that it has enjoyed consistent public support. A defined contribution program would create a two-tiered system, with the less wealthy being forced into plans with less coverage and benefits than the plans available to the wealthy. This would not only be unjust, but also politically unwise, since it would undermine public support for the program.

On a practical level, a defined contribution program places too much faith in the ability of frail beneficiaries to "shop" for coverage and make a wise choice among competing plans. The example of the federal employees health benefits program (FEHBP) may not be illustrative of the impact of a similar program on the elderly and disabled, since the federal employee workforce is generally better-educated, younger, and healthier than the Medicare population. The elderly and disabled would be far more vulnerable to abusive marketing practices. They would be at greater risk of purchasing plans that provide inadequate coverage for their medical conditions. The only plans that lower income beneficiaries may be able to afford would be ones with very high deductibles and co-payments, imposing a harsh financial barrier on their access to care.

ACP-ASIM can support, however, a well-designed demonstration project to test the impact of a defined *benefit* voucher program, one which guarantees that the federal contribution will be sufficient to purchase a package of benefits equal to the current program.

Another option for maintaining the continued solvency of Medicare is to postpone the age of eligibility. The argument for postponing eligibility age past 65 is that beneficiaries are living longer than when Medicare is enacted, and that this demographic shift would justify a delay in the age of eligibility. However, ACP-ASIM is concerned that the consequence of such a change, in the absence of a program to provide universal coverage to all Americans, is that the number of uninsured would increase because retirees would no longer have coverage through an employer, but would be ineligible for Medicare for a longer period of time.

Requiring higher-income beneficiaries to pay more into the program has also been advanced as a way of helping to extend the solvency of the program. From a standpoint of fairness, ACP-ASIM agrees that it is appropriate to ask higher income beneficiaries to contribute a greater share to the program.

Maintaining the solvency of the Medicare program will entail a combination of methods: changes in benefits and cost-sharing, greater contributions from higher income beneficiaries, and consideration of the viability of a defined benefit program after thorough pilot-testing. However, ultimately it may be necessary to provide more funding to the program through payroll taxes and other sources. While raising taxes is not considered to be politically realistic at this time, such measures cannot be ruled out if the Medicare program is going to endure for future generations.

Congress should consider changes to improve Medicare's long-term solvency, but such changes should not lead to more uninsured Americans or violate the basic commitment to provide all beneficiaries, regardless of income, with access to comparable services. Specifically:

1. Congress should *not* convert Medicare into a defined *contribution* program.

2. A defined *benefit* voucher program should be tested on a demonstration project basis before a decision is made to implement it on a national basis. The demonstration project should assess the impact of a defined benefit voucher system on adverse selection, continuity of care, fairness, access (especially for lower income beneficiaries) and administrative costs of care.
3. Congress should *not* advance the age of eligibility for Medicare to be consistent with that of Social Security, unless an alternative program is in place to provide coverage to retired individuals who would not have access to employer-paid coverage until they reach the extended age of Medicare eligibility.
4. ACP-ASIM supports requiring that higher income beneficiaries pay higher premiums to remain in conventional Medicare.

If necessary, ACP-ASIM would support mandating a modest increase in the Medicare payroll tax *now* and/an increase in general revenue contributions to ensure the viability of Medicare for future generations.

Conclusion

ACP-ASIM is pleased that the Administration has outlined important steps in reforming the Medicare program. The College stands ready to assist the administration and members of Congress to implement the recommendations identified in our statement that will ensure: outdated Medicare benefits package that excludes life-saving medications and preventive services be provided; elimination of complex and unnecessary paperwork that diminishes the time physicians can spend with patients; and that inadequate reimbursement for covered services would be improved.



AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

ACP-ASIM References

1. Estimates of the Impact of Selected Medicare Changes. Prepared by the Lewin Group for the American College of Physicians. 1997.
2. Reforming Medicare: Adapting a Successful Program to Meet New Challenges. American College of Physicians. 1997.
3. Converting Medicare to a Defined Contribution Program. American College of Physicians-American Society of Internal Medicine. 1999.
4. Ambulatory Care Formularies and Pharmacy Benefit Management by Managed Care Organizations. American College of Physicians-American Society of Internal Medicine. 2001
5. Providing Medicare Beneficiaries with a Prescription Drug Benefit: Whom Do We Target and How Do We Deliver? American College of Physicians-American Society of Internal Medicine. 2002.
6. Policy memorandum on Adding Preventive Benefits to Medicare, Establishing a Drug Discount Program, and Altering Cost-Sharing Requirements, February 2002.