Committee on Energy and Commerce

Opening Statement as Prepared for Delivery
of
Health Subcommittee Ranking Member Diana DeGette

Hearing on "Examining the Medicare Physician Fee Schedule, MACRA, and Opportunities for Payment Reforms"

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Medicare payment to physicians impacts not only the 70 million Medicare beneficiaries, but essentially all patients, given that more than 95 percent of clinicians are paid through the program. Payment through Medicare's physician fee schedule is a critical funding source for clinicians—the program pays for about 9,000 types of medical services and accounts for a fourth of total national spending on physician and clinical services. But these payments aren't keeping up with inflation, which means America's physicians are paid less and less each year.

In fact, Medicare physician payment has declined 33 percent in real terms since 2001. I challenge everyone here to think of any other profession that receives a pay cut each year. And payment rates under Medicaid are even more dismal— while rates vary widely by state, Medicaid fee-for-service payments to physicians are significantly lower than Medicare payments. This delta between Medicaid and Medicare will continue to grow as states lower Medicaid payment rates in the wake H.R.1—in my home state of Colorado, Medicaid providers will take a pay cut so the state can contend with Republicans' massive new cost burdens.

Nowhere is this a bigger issue than in primary care. Access to primary care is the backbone of a healthy population. Primary care can serve as a critical entry point to the health care system, providing chronic disease prevention and healthy lifestyle promotion through trusted, long-term relationships between clinicians and patients.

Systems based on primary care are associated with greater health equity, better health outcomes, and lower health care expenditures. But due to the inadequacy of payments and cumbersome administrative processes the number of primary care physicians billing the Medicare fee schedule has slowly declined over the last several years. And fewer medical school graduates are choosing primary care over higher-paid careers in specialty care, healthcare administration, or concierge care, because lifetime earnings for primary care physicians average as much as 2.5 million dollars below their specialist peers.

As a result, more than 100 million Americans don't have access to regular primary care. These 100 million Americans are without a reliable touchpoint to health care and lack coordinated management of their diabetes, asthma, or blood pressure, which means they can have undiagnosed medical issues for years and may be forced to delay care until their preventable conditions become a health crisis.

Across specialties, low payment rates force clinicians to weigh fundamentally impossible decisions. Do they continue to accept Medicare patients and threaten their own financial stability to the point of selling their practice outright, or take only patients with commercial insurance and diminish beneficiaries' access to care? Do they pursue medical fields based on patient need, or seek out specialties for which they will be adequately compensated and can finally pay off their mountain of medical school debt?

Serving our nation's seniors and individuals with disabilities should not be seen as a liability—they deserve the dignity of the best access to care. That's why even MedPAC—which is not exactly known for recommending reckless spending of tax dollars—has called for an inflationary update to Medicare physician payments.

An increase based on the Medicare Economic Index, among other reforms, will not only ensure payment keeps up with rising input costs, but also simplify the health care payment system. Additionally, Congress must work to close the large compensation gap between specialists and primary care physicians to double the number of medical school graduates going into generalist fields who can manage multiple chronic diseases and prevent illness before it happens. We need to expand payment structures that incentivize comprehensive, longitudinal care over quantity or complexity of procedures performed.

I have confidence that this issue—of reforming physician payments to increase access to quality health care, starting with robust primary care—is one that we all agree is urgent and deserves our full attention. I look forward to hearing from our witnesses today and I look forward to working with my colleagues to address not just Medicare pay, but the incentive structure that prefers expensive, delayed interventions that leave patients sicker, over earlier, more holistic care.