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April 24, 2018

The Honorable Jim Wood
Chair, Assembly Health Committee
Capitol State Assembly
Capitol Office, Room 6005
PO Box 942849
Sacramento, CA 95814

Re: AMA Opposition to Assembly Bill 3087

Dear Assembly Member Wood:

On behalf of the American Medical Association (AMA) and its physician and student members, I write to state our opposition to Assembly Bill (AB) 3087 and urge you to oppose the measure as well. The AMA shares your Committee's concern over health care costs and is working on many fronts to improve access to affordable, quality health care. However, we do not believe the price-fixing proposals in AB 3087 will further this goal.

AB 3087 does not take steps to meaningfully address the underlying causes of rising health care costs which include long-term care costs, access to preventative care, chronic disease, prescription drugs, mental health parity enforcement, administrative and regulatory burdens, cost transparency, the medical liability system, marketplace competition, patient health insurance literacy and many more complicated issues. Instead, AB 3087 would use a blunt tool – price fixing – which would undoubtedly have harmful, long-term implications on health care and health insurance in California.

The AMA believes that AB 3087 would reduce payment to physicians, despite the fact that physician payments are not major drivers of increasing health care costs. In fact, prices for physician services in the U.S. have grown slowly over the last 10 years. For example, between 2006 and 2016 prices have gone up by an average of only 1.2 percent per year,¹ and data suggest that recent growth has been even slower. Moreover, physicians do not take home all of what is spent on the services they provide – they must pay for staff and other office and administrative expenses. After accounting for those expenses, physician income is only around 8 percent of total national health care spending.

In determining fixed payments for physicians, the commission established under AB 3087 would create a system based on Medicare rates. Unfortunately, the use of Medicare as a benchmark is unsustainable. Medicare uses the resource-based relative value scale (RBRVS) system to establish physician payments, but, before Medicare rates are finalized, they go through adjustment and conversion processes to meet federal budgetary requirements. The geographically adjusted rate is multiplied by a conversion factor that determines the final Medicare payment. The conversion factor is a monetary payment determined by

¹ Bureau of Labor Statistics, producer price index: offices of physicians

Medicare each year and adjustments to the conversion factor are typically based on the Medicare economic index, adjustments pertaining to budget neutrality and other adjustments stipulated by legislation. After everything is complete, including the artificial adjustments, the resulting payment rates are not generally reflective of market rates for physician services.

In fact, Medicare physician payments have increased just 6 percent from 2001 to 2017 or 0.4 percent per year on average, and when adjusted for inflation, Medicare physician pay has declined 19 percent from 2001 to 2017.² Meanwhile, the cost of running a medical practice (e.g. office rent, employee wages, professional liability insurance, etc.) has increased 30 percent in that same timeframe. Using Medicare to establish payments in the private market will simply undercut the financial stability of physician practices.

All of this would generate an unfriendly environment for current and future physicians in California. Physicians across California will feel the impact of this legislation on their bottom lines, forcing them to make tough decisions that may include closing their practices and leaving the state. Moreover, AB 3087 provisions would have a negative effect on California's historically strong capacity for retaining physicians who have trained in the state, and in whom the state has invested so much. All this could lead to access issues for Californians, especially when combined with already looming physician workforce shortages.

California's economy may feel the pain of destabilized physician practices, as well. In California alone, physicians support 1.2 million jobs, generate \$232 billion in economic output, and contribute \$11.2 billion in state and local tax revenues.³ As such it is vital to support physician practices as the economic drivers in their communities that they are, and recognize the far ranging impact that undercutting the stability of these practices will have on the state economy.

Finally, AB 3087 may reduce health care delivery innovation in California. For most physician practices, extra resources often go to improving practice efficiencies, experimenting with new payment models, or investing in electronic health records. These types of physician investments are helping to build the foundation for major innovations and improvements in health care delivery. There is no question that California is a hotbed of health care innovation and there should be no doubt that maintaining an environment that is supportive and fair to physicians, as well other health care stakeholders, is critical.

In conclusion, the AMA watches closely the policy innovations that come out of California and the thoughtful and tough debates that happen among California policymakers and other stakeholders on health care. While we may not always agree with the proposals or solutions that are considered in California, the AMA recognizes California as a leader that rarely takes the easy way out on policy deliberations. Unfortunately, AB 3087 would be taking the easy way out on one of the most important of health care debates. We ask that you immediately withdraw this legislation, and we would look forward to working with California lawmakers and the California Medical Association toward meaningful, albeit complicated, solutions to health care costs.

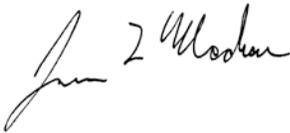
² Medicare Trustees' Report and U.S. Bureau of Labor Statistics

³ The Economic Impact of Physicians in California, IQVIA (January 2018)

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If you have any questions, please contact Emily Carroll, JD, Senior Legislative Attorney, Advocacy Resource Center, at emily.carroll@ama-assn.org or (312) 464-4967.

Sincerely,

A handwritten signature in black ink, appearing to read "Jim L Madara". The signature is written in a cursive style with a large initial "J" and "M".

James L. Madara, MD

cc: California Medical Association
Jack Resneck, Jr., MD
Ryan J. Ribeira, MD, MPH
Karthik V. Sarma, MS