American Society *of* Interventional Pain Physicians®
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Senator Bill Cassidy, MD
Chairman, Committee on Health, Education, Labor, and Pensions
455 Dirksen Senate Office Building
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Re: A Non-Partisan Proposal from ASIPP for Budget Reconciliation Preserving Medicare and Medicare and Reforming Physician Payment System

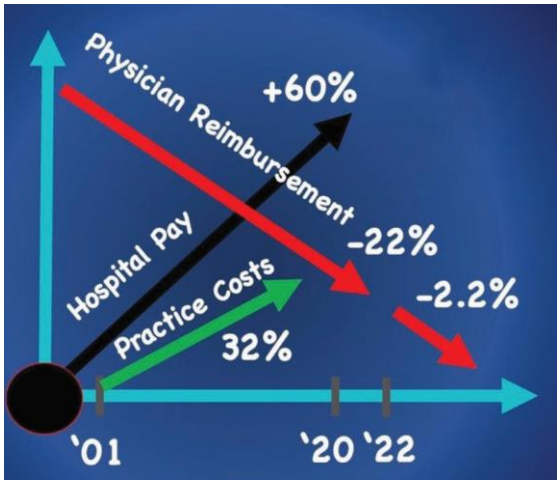
Dear Honorable Dr. Cassidy:

Thank you for your efforts in addressing a range of critical issues, including physician payment reform, which unfortunately remains a low priority for many. Nevertheless, it is important to recognize that financially unsustainable medical practices cannot maintain high standards of care, and patient access will inevitably be compromised—regardless of prevailing expert opinions.

On behalf of the American Society of Interventional Pain Physicians (ASIPP), the Louisiana Society of Interventional Pain Physicians, 47 other state societies, and our national membership, we are reaching out to express serious concerns regarding ongoing challenges within the Medicare and Medicaid programs.

We commend President Trump's commitment to safeguarding Medicare and Medicaid from budgetary cuts. However, it is imperative that this commitment also encompass the preservation of fair and sustainable physician payments and reimbursements. Unfortunately, physicians remain in a state of uncertainty, with only the prospect of potential relief in 2026—a proposal that may never materialize. Meanwhile, our practices are facing immediate and mounting pressures due to rising costs of operations, supplies, labor, and continual reimbursement reductions across all payers.

The following chart illustrates the decline in physician payments over time. Physicians are currently earning less, in real terms, than they did in 2001, as reflected by the conversion factor. Additionally, the ongoing 2% sequestration cuts—initiated after the passage of the Affordable Care Act—continue to compound these reductions, yet are rarely acknowledged in public discourse. When combined, these factors represent an overall decrease of approximately 55% in physician compensation compared to 2001.



Comparison of declining physician reimbursement compared to practice costs and hospital reimbursement.

Source: Green HA. The only four products of healthcare manufacture and produced with American patients. LinkedIn, January 14, 2023. https://www.linkedin.com/pulse/four-products-healthcare-manufactured-produced-howard-a-green-md/

The continued application of sequestration cuts remains a significant, yet under-discussed, burden on the physician community. These reductions must be addressed directly and transparently.

While the "Big, Beautiful Bill" proposes an $8.9 billion investment into the Medicare Physician Fee Schedule, offering a 2.25% update in 2026, it falls short in subsequent years. Beyond 2026, updates would be tied to only 10% of the Medicare Economic Index (MEI)—a mere 0.3% annual increase—which does not even begin to reflect actual inflation or the escalating cost of providing care. The current proposal, as written, fails to:

- Adequately address inflationary trends or the rising costs of medical practice;
- Account for budget neutrality adjustments;
- Remedy structural deficiencies in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), particularly within the Merit-Based Incentive Payment System (MIPS);
- Eliminate or mitigate the continuation of the 2% sequestration cuts;
- Prevent future cuts, such as the 4% PAYGO reductions, which could be triggered at any time and pose a serious risk to physician stability.

In response, ASIPP has submitted a Non-Partisan Proposal for Budget Reconciliation, which offers reforms to the physician payment system and protections for telehealth services. This proposal presents two distinct plans:

Plan One: Avoids any substantive cuts to Medicare and Medicaid programs.
Plan Two: Incorporates selective reductions, targeting excessive and abusive payment practices, while preserving essential physician services.

The table below outlines our non-partisan proposal, designed to achieve fiscal responsibility over a 10-year horizon while supporting the sustainability of physician practices and access to high-quality care.

A non-partisan proposal for budget reconciliation over 10 years.

Savings **CBO Recommended and Congress Proposed**	**Costs of Physician Priorities**
• Site-neutral payments: $146 billion • 340B Drug Pricing Program: $73 billion • Elimination of uncompensated Care: $229 billion • Elimination of Bad Debt: $42 billion **Total Savings: $490 billion**	• Reforming Physician Payment System: $240 billion • Elimination of Sequestration Cuts: $62 billion • Telehealth Costs: $20 billion **Total Costs of Proposed Policy Changes: $322 billion**
Without Medicare & Medicaid Cuts	**With Cuts as Proposed Originally**
CBO/Congress Savings: $271 billion Other Savings from Medicare Advantage Plans: $1.2 trillion **Total Savings: $1.441 trillion** Physician Reform Costs: $322 billion **Net Savings: $1.119 trillion**	CBO/Congress Savings: $490 billion Other Savings from Medicare Advantage Plans: $1.2 trillion **Total Savings: $1.69 trillion** Physician Reform Costs: $322 billion **Net Savings: $1.368 trillion**

We urge policymakers to consider these practical, evidence-based solutions and to recognize the urgent need for immediate action to protect physicians, patients, and the integrity of our healthcare system.

To reiterate:

Health care spending in the United States continues to escalate, reaching $4.9 trillion in 2023—a 7.5% increase from the previous year (1). Medicare remains a significant and rapidly expanding component of the federal budget. Estimates from the Medicare Payment Advisory Commission (MedPAC) (2), the Congressional Budget Office (CBO) (3), and other sources indicate that net Medicare spending—after accounting for beneficiary premiums—is projected to total $14 trillion over the next decade. The Medicare Hospital Insurance (HI) Trust Fund, which finances Part A and constitutes approximately 40% of Medicare and 20% of total national health spending, is projected to be depleted by 2036.

PHYSICIAN PAYMENT CUTS:
Simultaneously, the financial sustainability of physician practices is increasingly under pressure. Over the past 24 years, physician payment rates have declined by 33%, while practice costs have steadily risen (4) (Fig. 1). The cost of medical equipment, supplies, and technology has grown from $30.2 billion in 2017 to $57 billion in 2023, reflecting an average annual growth rate of 6.5%. In reality, the overall increase in practice expenses may be even greater, compounding the financial challenges faced by providers. Additionally, a widening gap has emerged: while physician payments have declined, other health care sector payments have continued to rise. Perhaps most striking is the contrast between insurance premium growth and physician reimbursement rates, with premiums increasing nearly 400% while physician payments have dropped by 33%.

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) released its final rule on physician payment policy (5), introducing several major changes. Notably, the rule eliminated certain telehealth services and implemented a 2.8% reduction in payments for physician services—an estimated annual cut of $20 billion.

These reductions stem from the expiration of temporary payment increases that had been used in recent years to mitigate previous conversion factor cuts: a 3.75% increase in 2021, followed by 3% in 2022, 2.5% in 2023, and a projected 2.93% for 2024. The final rule also upheld the 0% budget neutrality requirement, which continues to trigger conversion factor reductions.

Additionally, physicians remain subject to ongoing 2% sequestration cuts mandated by the Budget Control Act of 2011. These cuts, which are expected to persist through 2034, support funding for the Affordable Care Act (ACA) through automatic, across-the-board reductions in federal spending.

REWARDS TO MEDICARE ADVANTAGE PLANS:

In contrast to these ongoing cuts to traditional Medicare, CMS announced on January 10, 2025, a proposed 4.3% payment increase for Medicare Advantage plans (6). This increase is expected to amount to $21 billion in 2026 alone and approximately $210 billion over the subsequent decade. The proposal comes amid growing scrutiny over Medicare Advantage overpayments, which include an estimated $44 billion due to favorable selection, $40 billion from inaccuracies in risk adjustment, and $15 billion for care of veterans already covered under Veterans Administration (VA) benefits. Meanwhile, traditional Medicare beneficiaries are shouldering higher costs, contributing an additional $198 annually per beneficiary—totaling roughly $13 billion each year, according to the MedPAC (3). In fact, OIG-HHS requested Congressional action reform Medicare Advantage with $17 billion (7).

MEDICARE AND MEDICAID INSOLVENT:

Both the MedPAC and the CBO have recommended eliminating bonus payments awarded to Medicare Advantage plans through the star rating system, along with adjustments based on risk scoring—measures that collectively cost $84 billion in 2023 (2,3). A growing consensus among experts and policy publications is calling for comprehensive reform of Medicare Advantage payments. Additionally, the Department of Justice has filed multiple lawsuits against Medicare Advantage plans alleging misuse, abuse, and fraud. Recently, Humana's star ratings have been impacted as part of increased scrutiny. At the same time, patient financial burdens have continued to rise sharply, with total copays and deductibles exceeding $10,000 annually in some plans. Notably, there have been alarming trends such as copays reaching $750 for outpatient procedures, deductibles as high as 20% of total charges, and increasing denials of medically necessary services.

CONGRESSIONAL INABILITY:

Meanwhile, Congress has so far failed to enact reforms to the physician payment system for 2025, with any possibility of retroactive adjustments still uncertain and unlikely. Despite growing concerns, lawmakers remain largely unwilling to address Medicare Advantage spending, instead authorizing CMS to continue increasing plan payments without implementing significant oversight or structural changes.

Amid this fiscal environment, the Trump administration and Congress implemented several budgetary savings over the next decade using the budget reconciliation process. These savings primarily target fraud and abuse, along with notable reductions in the Supplemental Nutrition Assistance Program (SNAP) and issues related to program enrollment. Although work requirements for able-bodied Medicaid recipients have been in place for years across several states, the overall effectiveness of these policies remains uncertain. Nevertheless, while these cuts continue, Congress and the CMS persist in allocating financial incentives to Medicare Advantage plans (8).

ASIPP'S PROPOSAL

ASIPP's recommendations build upon previous analyses from MedPAC, CMS, OIG-HHS, and the CBO. Our proposal aims to achieve savings through various avenues, including $62 billion from continuing sequestration cuts, $146 billion via site-neutral payment reforms, $73 billion by restructuring the 340B drug pricing program, $229 billion from eliminating payments for uncompensated care, and $42 billion through the removal of bad debt reimbursements.

The largest projected savings are expected to result from proposed reforms to the Medicare Advantage program. Estimated savings from specific changes include:

1. Cancellation of the proposed 4.3% payment increase for 2026:
   $21 billion per year, or $210 billion over 10 years
2. Elimination of payments for veterans already covered by VA insurance:
   $15 billion per year, or $150 billion over 10 years
3. Ending favorable selection practices:
   $44 billion per year, or $440 billion over 10 years
4. Reforming risk adjustment mechanisms:
   $40 billion per year, or $400 billion over 10 years

Collectively, these measures would generate an estimated $120 billion in annual savings from the Medicare Advantage program—totaling $1.2 trillion over a 10-year period.

By incorporating targeted adjustments—such as implementing physician payment reforms and reversing sequestration cuts—while preserving key recommendations from MedPAC (2), the CBO (3), and maintaining alignment with the goals of the House Energy and Commerce Committee, it is possible to meaningfully reform the physician payment system without reducing Medicaid funding. This strategy remains viable within the constraints of the current budget reconciliation framework.

Assuming the President's position of avoiding direct Medicare or Medicaid cuts remains unchanged, savings from site-neutral payment reforms ($146 billion) and restructuring the 340B drug pricing program ($73 billion), totaling $219 billion, may be excluded from the final budget package. This would remove $271 billion in potential savings from the CBO and congressional projections. However, if offsetting reforms—such as eliminating payments for uncompensated care ($229 billion) and removing bad debt reimbursements ($42 billion)—are retained, total savings would still amount to $1.441 trillion. After accounting for excluded savings, the net savings would be $1.119 trillion, which is sufficient to meet the budget target (Table 1).

Alternatively, if the proposed hospital-related reforms, including the $146 billion from site-neutral payments and $73 billion from 340B restructuring, are maintained, these would contribute $219 billion in additional savings. Combined with the CBO-recommended and Congress-proposed measures, this would yield total projected savings of $1.69 trillion, resulting in net savings of approximately $1.368 trillion. A detailed breakdown of these projections is provided in Table 1.

As you see above, we have presented 2 plans, one with the original plan and the alternate one without any cuts to Medicare and Medicaid, yet we are able to save $1.119 billion over a period of 10 years.

We sincerely hope that you will consider these proposals seriously and help the community, most importantly patients and then physicians. Physician distress and inability to practice will affect the quality of patient care.

If you have any questions, please feel free to contact us.

Thank you,

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REFERENCES:

1. Martin AB, Hartman M, Washington B, Catlin A; National Health Expenditure Accounts Team. National health expenditures in 2023: Faster growth as insurance coverage and utilization increased. *Health Aff (Millwood)* 2025; 44:12-22.
2. Medicare Payment Advisory Commission. Report to Congress: Medicare Payment Policy. March 2025. Accessed 4/14/2025. https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf
3. Congressional Budget Office. Options for reducing the deficit: 2025 to 2034. December 2024. Accessed 4/30/2025. https://www.cbo.gov/system/files/2024-12/60557-budget-options.pdf
4. American Medical Association. Issue Brief: Medicare physician payment reform: The urgent need for comprehensive reform. Accessed 5/5/2024. https://www.ama-assn.org/system/files/2025-mac-medicare-physician-payment-issue-brief.pdf
5. Department of Health and Human Services, Centers for Medicare & Medicaid Services. 42 CFR Parts 401, 405, 410, 411, 414, 423, 424, 425, 427, 428, and 491 [CMS–1807–F and CMS–4201–F5]. Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments. Final rule. December 9, 2024.
6. Centers for Medicare and Medicaid Services. Press Release - CMS Releases Proposed 2026 Payment Policy Updates for Medicare Advantage and Part D Programs. January 10, 2025. Accessed 4/14/2025. https://www.cms.gov/newsroom/press-releases/cms-releases-proposed-2026-payment-policy-updates-medicare-advantage-and-part-d-programs

7. U.S. Department of Health and Human Services. Office of Inspector General. Potential Cost Savings in HHS Programs. May 5, 2025. Accessed 5/7/2025. https://oig.hhs.gov/documents/impact-briefs/10272/HHS-OIG-legislative-action-cost-savings.pdf
8. Williams E, Burns A, Rudowitz R. Putting $880 billion in potential federal Medicaid cuts in context of state budgets and coverage. *KFF*, March 24, 2025. Accessed 4/30/2025. https://www.kff.org/medicaid/issue-brief/putting-880-billion-in-potential-federal-medicaid-cuts-in-context-of-state-budgets-and-coverage/