Health Policy Perspective

Non-Partisan Proposal for Reforming Physician Payment System and Preserving Telehealth Services

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Background: Physician payments have declined significantly due to budget neutrality rules and reimbursement cuts. Since 2001, Medicare payments to physicians have dropped by 33% when adjusted for inflation. These reductions have been compounded by 2% annual sequestration cuts introduced after the Affordable Care Act (ACA), which continues through 2032. Despite their long-term impact, sequestration cuts receive little public attention.

Congress has historically delayed or softened these cuts. However, in 2025, a bill that would have adjusted payment rates was removed from the continuing resolution, resulting in continued reductions. Meanwhile, insurance premiums have risen nearly 400%, highlighting the disparity between healthcare costs and physician compensation.

Ironically, while physicians face significant payment cuts, the Centers for Medicare & Medicaid Services (CMS) proposed on January 10, 2025, a 4.3% payment increase for Medicare Advantage plans—totaling $21 billion in 2026 and an estimated $210 billion over the following decade starting in calendar year 2026. This proposal comes amid ongoing concerns about Medicare Advantage overpayments, estimated at nearly $100 billion annually, and additional funding through annual premiums of $198 from all Medicare beneficiaries, amounting to roughly $13 billion per year.
In response, the American Society of Interventional Pain Physicians (ASIPP) submitted a nonpartisan reform proposal advocating for telehealth protections and elimination of sequester cuts—measures that have received strong bipartisan support in Congress.

Current Status: Both the House of Representatives and the Senate voted to pass a reconciliation bill—nicknamed the "Big Beautiful Bill", which has been signed into law by the President recently. It proposes an $8.9 billion investment in the Medicare Physician Fee Schedule, with a 2.25% update in 2026.

The proposal does not address the budget neutrality provision, growing practice costs, inflationary pressures, or ongoing sequestration and pay-as-you-go (PAYGO) cuts. It also fails to resolve issues with the Medicare Access and CHIP Reauthorization Act (MACRA), particularly within the Merit-Based Incentive Payment System (MIPS).

Conclusion: On November 1, 2024, CMS finalized a 2.8% cut to physician payments—an estimated $20 billion—while also eliminating telehealth services. These cuts continue to threaten physician sustainability and patient access to care.

Key words: Physician payment reform, telehealth services, non-partisan proposal, Affordable Care Act (ACA), sequester cuts, budget neutrality adjustments, Pay-As-You-Go Act (PAYGO)

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On November 1, 2024, the Centers for Medicare and Medicaid Services (CMS) issued a final rule for physician payment (1), which included several significant changes. Among them was the elimination of certain telehealth services and a 2.8% reduction in payments for physician services—amounting to an estimated $20 billion per year.

These payment reductions resulted from the expiration of temporary increases that had been enacted to counter conversion factor cuts in prior years: 3.75% in 2021, 3% in 2022, 2.5% in 2023, and a projected 2.93% in 2024. The final rule incorporated a 0% budget neutrality and inflation update, which continues to drive down the conversion factor. In the Medicare program, budget neutrality mandates that any increase in payments for one service area must be offset by reductions in other areas, ensuring that overall Medicare spending remains stable despite changes in specific payment schedules. Unfortunately, physician payments are not indexed to inflation, leading to a 33% decline in inflation-adjusted reimbursement from 2001 to 2025. As a result, physician compensation continues to be undermined by frequent and significant redistributions driven by budget neutrality adjustments and the absence of inflationary updates. These budget neutrality provisions were established under the Omnibus Budget Reconciliation Act of 1989 and remain a fundamental component of Medicare payment policy (2).

Physicians are also subject to the ongoing 2% sequestration cuts, scheduled to remain in effect through 2032. These cuts, mandated under the Budget Control Act of 2011 (BCA) (3) to support the Affordable Care Act (ACA), result in automatic, across-the-board reductions in federal spending and have rarely been acknowledged in public policy debates. Sequestration is not subject to the discretion of the President or Congress; it is triggered automatically when spending limits are exceeded. Generally, sequestration imposes equal percentage cuts across all non-exempt programs. It is intended to motivate lawmakers to stay within budgetary constraints or to pass legislation that meets specific fiscal objectives. The Budget Control Act of 2011 introduced sequestration as part of a broader strategy to reduce the federal deficit and rein in government spending. Additionally, the Fiscal Responsibility Act (FRA) included a potential sequestration mechanism that could be activated if Congress fails to complete the appropriation process for fiscal year 2024 (4). This mechanism has been shown to be effective through 2032. However, the White House Office of Management and Budget (OMB) reported that sequestration is not required for the current fiscal year, as enacted appropriations remain within the established discretionary spending limits. Even then, sequestration is alive and well, continuously draining physician practices.

Additionally, although physicians temporarily avoided a 4% reduction under the Pay-As-You-Go (PAYGO) provisions, that threat remains (5). The Statutory Pay-As-You-Go Act of 2010 (5), signed into law by President Obama, mandates automatic cuts when new legislation adds to the federal deficit. The Statutory Pay-As-You-Go Act of 2010 (PAYGO) requires Congress to offset any new legislation that increases the federal deficit, whether through increased spending or tax cuts. If a bill is projected to add to the deficit, automatic spending reductions are triggered to offset the increase. Unfortunately, the Big Beautiful Bill may increase the deficit, thereby activating PAYGO provisions. According to the House Budget Committee Report from the Democrats, this would result in an automatic 4% cut to most Medicare spending, including payments to hospitals, physicians, and Medicare Advantage Plans. The Congressional Budget Office (CBO) estimates that the bill would lead to a $45 billion reduction in Medicare funding in 2026, increasing to $75 billion by 2034. Unlike sequestration cuts, Congress has the authority to prevent PAYGO cuts by taking action before the end of the year. In the past, they have done so by either excluding the legislation from the PAYGO scorecard or passing measures to delay or cancel the cuts altogether. However, repeated delays are dangerous—as the cuts accumulate, we may eventually face reductions as high as 20%.

In contrast, on January 10, 2025, CMS proposed a 4.3% payment increase to Medicare Advantage Plans, amounting to $21 billion in 2026 and approximately $210 billion over the following decade (6). This proposal comes amid growing concerns about Medicare Advantage overpayments, including $44 billion due to favorable selection, $40 billion from risk adjustment discrepancies, and $15 billion for duplicative coverage of veterans who already receive benefits through the Veterans Administration (VA). According to the Medicare Payment Advisory Commission (MedPAC), traditional Medicare beneficiaries also face higher costs, contributing an additional $198 annually—totaling roughly $13 billion per year (7-15).

The proposed budget reconciliation bill—referred to as the "Big Beautiful Bill"—includes an $8.9 billion investment into the Medicare Physician Fee Schedule

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and offers a 2.25% payment update in 2026 (16). However, beyond that, updates would be limited to only 10% of the Medicare Economic Index (MEI)—resulting in an approximate 0.3% annual increase. This approach falls significantly short of addressing inflation or the rising cost of delivering care. A CBO estimate of bills introduced in Congress projected annual expenditures of $20 billion, amounting to $240 billion over a 10-year period—significantly higher than the originally proposed $8.5 billion, which is considered highly inadequate (17,18). Furthermore, the Senate eliminated this provision. The proposal fails to:

- Adequately account for inflation or the increasing cost of medical practice (16-21)
- Address budget neutrality adjustments (19,20);
- Remedy structural deficiencies in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), especially the Merit-Based Incentive Payment System (MIPS) (21);
- Eliminate or mitigate the continuing 2% sequestration cuts;
- Prevent future reductions such as the 4% PAYGO cuts, which remain a serious threat to physician stability.

The actual cost for appropriate physician payment reform is $24 billion annually—or $240 billion over 10 years—not the $8.9 billion currently proposed (16-21).

Figure 1 illustrates the continuing decline in physician payments. In real terms, physicians are earning 33% less than they did in 2001, based on the conversion factor. The ongoing 2% sequestration cuts—implemented after passage of the ACA—continue to compound these reductions and are rarely acknowledged in public forums. Additionally, the continued threat of a 4% PAYGO cut could result in total reductions of up to 9% in the coming years. These cuts come despite growing payments to other healthcare sectors, particularly Medicare Advantage. In addition, the continuous expansion of regulations, preauthorization requirements, and rising practice costs have significantly reduced utilization patterns for interventional techniques—by as much as 25% over the past few years and approximately 5% to 10% annually (22-27). Furthermore, similar to trends seen in other specialties, reimbursements for interventional techniques have declined, with an estimated 33% decrease in inflation-adjusted payments since 2001 (28).

In response, the American Society of Interventional Pain Physicians (ASIPP) has submitted a Non-Partisan Proposal for Budget Reconciliation, offering substantive reform to the physician payment system and safeguards for telehealth services. The proposal outlines a strategic plan:

Table 1 outlines the ASIPP proposal in detail, showing how it can promote fiscal responsibility over a 10-year horizon while ensuring sustainability for physician practices and continued access to high-quality care.

On a national level, healthcare spending in the U.S. continues to escalate, reaching $4.9 trillion in 2023—a

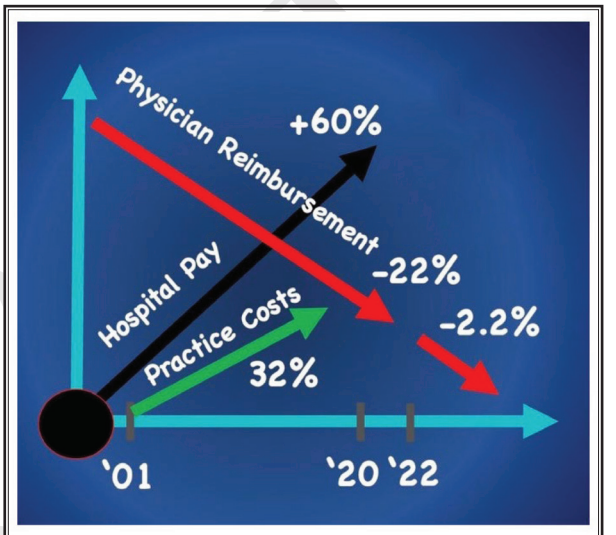


Fig. 1. *Comparison of declining physician reimbursement compared to practice costs and hospital reimbursement.* Source: Green HA. The only four products of healthcare manufacture and produced with American patients. LinkedIn, January 14, 2023. https://www.linkedin.com/pulse/four-products-healthcare-manufactured-produced-howard-a-green-md/

Table 1. *A non-partisan proposal for budget reconciliation of $878 billion over 10 years.*

SAVINGS
Savings from Medicare Advantage Plans: $1.2 trillion
Costs of Physician Priorities
• Reforming Physician Payment System: $240 billion • Elimination of Sequestration Cuts: $62 billion • Extension of telehealth services: $20 billion Total Costs of Proposed Policy Changes: $322 billion
Proposal for Physician Payment Reform
Savings from Medicare Advantage Plans: $1.2 trillion Total Savings: $1.2 trillion Physician Reform Costs: $322 billion Net Savings: $878 billion

7.5% increase over the prior year (29,30). Medicare remains one of the largest and fastest-growing components of federal spending. According to MedPAC (7), the CBO (31), and other sources, net Medicare spending (after accounting for premiums) is projected to reach $14 trillion over the next decade. The Medicare Hospital Insurance (HI) Trust Fund—which funds Medicare Part A and accounts for about 40% of Medicare spending (or roughly 20% of all U.S. health expenditures)—is projected to become insolvent by 2036.

Both MedPAC and the CBO have recommended eliminating certain overpayments within the Medicare Advantage program. These include $84 billion in bonuses awarded through the star rating system and inflated payments driven by risk scoring adjustments (7).

Meanwhile, Congress has yet to pass physician payment reform for 2025 and discussions about retroactive solutions remain ongoing. Despite these pressing fiscal concerns, the Trump administration's current budget reconciliation framework identifies more than $1 trillion in potential federal savings over the next decade. These would come from programs overseen by the House Energy and Commerce Committee and the Senate Finance Committee, including Medicaid. However, these savings proposals have sparked intense partisan debate, with critics warning of negative consequences for patients and state budgets (31,32).

ASIPP's proposal builds on prior analyses and recommendations from CMS, MedPAC, and the CBO. The most significant savings, however, are projected to come from reforms to the Medicare Advantage program:

1. Canceling the proposed 4.3% increase in 2026: $21 billion annually / $210 billion over 10 years
2. Eliminating duplicative VA coverage payments: $15 billion annually / $150 billion over 10 years
3. Ending favorable selection practices: $44 billion annually / $440 billion over 10 years
4. Reforming risk adjustment mechanisms: $40 billion annually / $400 billion over 10 years

These reforms together would yield $120 billion in annual savings, or $1.2 trillion over a decade.

With modest policy adjustments, including physician payment reform and repeal of sequestration cuts, it is possible to achieve a sustainable physician payment system within the current budget reconciliation process.

ASIPP's detailed projections are outlined in Table 1.

Discussion

Health care spending in the United States continues to rise sharply, reaching $4.9 trillion in 2023—a 7.5% increase over the previous year (30). Medicare remains a central and fast-growing component of the federal budget. According to estimates from MedPAC (7), the CBO (31), and other sources, 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 accounts for approximately 40% of Medicare spending and 20% of total national health expenditures, is expected to be exhausted by 2036.

Physician Payment Cuts

At the same time, physician practices face mounting financial strain. Over the past 24 years, physician payment rates have declined by 33%, even as practice costs have steadily increased (33) (Fig. 1). The cost of medical equipment, supplies, and technology alone has surged—from $30.2 billion in 2017 to $57 billion in 2023—an average annual growth rate of 6.5%. Actual increases in total practice costs may be even higher, compounding the economic pressures faced by providers. A striking disparity has emerged: while physician reimbursements have decreased, payments across other healthcare sectors have grown significantly. Notably, insurance premiums have risen nearly 400% over the same period, underscoring the imbalance.

On November 1, 2024, CMS released its final rule for physician payment policy (1), introducing several major changes. These included the elimination of specific telehealth services and a 2.8% reduction in physician payments—amounting to an estimated annual cut of $20 billion.

These reductions were largely due to the expiration of temporary payment increases used in prior years to mitigate conversion factor cuts: 3.75% in 2021, 3% in 2022, 2.5% in 2023, and a projected 2.93% in 2024. The rule also retained the 0% budget neutrality and inflation adjustments, which continues to drive down the conversion factor and, in turn, physician payments.

In addition, physicians remain subject to ongoing 2% sequestration cuts, mandated under the Budget Control Act of 2011. These cuts, intended to help fund the ACA, are automatic and across-the-board—and are currently projected to remain in place through 2034.

Rewards for Medicare Advantage Plans

In stark contrast to cuts under traditional Medicare,

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CMS announced on January 10, 2025, a proposed 4.3% increase in payments for Medicare Advantage Plans (6). This change would increase federal spending by $21 billion in 2026 alone and by approximately $210 billion over the next decade. These increases have drawn criticism, especially in light of widespread concerns about overpayments. Key issues include an estimated $44 billion annually due to favorable selection, $40 billion from inaccuracies in risk adjustment, and $15 billion for duplicative coverage of veterans already receiving care through the VA. Meanwhile, traditional Medicare beneficiaries are bearing increased out-of-pocket costs—an additional $198 per person annually, amounting to about $13 billion in aggregate each year (31). The Office of Inspector General for the Department of Health and Human Services (OIG-HHS) has also urged Congress to reform Medicare Advantage, citing $17 billion in necessary adjustments (34).

Medicare and Medicaid Insolvency

Both MedPAC and the CBO have recommended eliminating $84 billion in bonus payments awarded through the Medicare Advantage star rating system and revising inflated risk scoring methodologies (7-15,31,35-40). A growing consensus—including experts, government agencies, and published reports—calls for structural reforms to Medicare Advantage payment policies. Additionally, the Department of Justice has filed multiple lawsuits against Medicare Advantage Plans for fraud, waste, and abuse. Recent enforcement actions have included penalties impacting Humana's star ratings, highlighting the increased scrutiny.

Simultaneously, patient financial burdens have escalated dramatically. In some Medicare Advantage Plans, annual out-of-pocket costs—including deductibles and copays—now exceed $10,000. Copays for certain outpatient procedures have reached as high as $750, with coinsurance rates of up to 20%, and denials of medically necessary care continue to rise.

Congressional Inability

Despite mounting concerns, Congress has failed to pass meaningful physician payment reform for 2025. The prospect of retroactive adjustments remains uncertain and unlikely. Lawmakers have also avoided addressing rising Medicare Advantage spending, instead authorizing CMS to continue increasing payments without instituting effective oversight or structural change.

Amid this fiscal backdrop, the Trump administration and Congress have implemented several budget savings initiatives through the budget reconciliation process. These include efforts to reduce fraud and abuse, as well as proposed cuts to the Supplemental Nutrition Assistance Program (SNAP) and changes in eligibility and enrollment standards. Although several states have already implemented work requirements for able-bodied Medicaid recipients, the long-term impact of these policies remains unclear. Nonetheless, while key safety-net programs are subjected to fiscal constraints, Medicare Advantage continues to receive generous increases in federal funding (32).

ASIPP's Proposal

ASIPP's recommendations are informed by extensive analyses from MedPAC, CMS, OIG-HHS, and the CBO. Our proposed savings approach includes:

- $62 billion from continuing sequestration cuts;
- $146 billion from implementing site-neutral payment policies;
- $73 billion from restructuring the 340B drug pricing program.

However, the largest savings would come from reforms to Medicare Advantage. Estimated savings from specific changes include:

1. Canceling the proposed 4.3% payment increase for 2026: $21 billion per year / $210 billion over 10 years
2. Eliminating duplicative payments for VA-covered veterans: $15 billion per year / $150 billion over 10 years
3. Ending favorable selection practices: $44 billion per year / $440 billion over 10 years
4. Reforming risk adjustment methodologies: $40 billion per year / $400 billion over 10 years

Collectively, these reforms could generate $120 billion in annual savings—or $1.2 trillion over a decade—from Medicare Advantage alone.

By implementing targeted reforms—such as modernizing physician payment systems and eliminating the sequestration cuts—while upholding essential recommendations from MedPAC (7), the CBO (31), and OIG-HHS (34), and remaining aligned with the fiscal goals of the House Energy and Commerce Committee and the Trump administration, it is possible to achieve physician payment reform without reducing Medicaid funding. This strategy is fiscally sound and remains feasible within the current budget reconciliation framework.

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Conclusion

We hereby present a non-partisan proposal aimed at reforming the physician payment system and preserving telehealth services, structured to comply with the constraints of the budget reconciliation process.

The proposal relies exclusively on savings from the Medicare Advantage program, projected to total $1.2 trillion over a 10-year period.

In this proposal, total projected savings are aligned with key physician priorities, which include:

- Reforming the physician payment system beyond MEI adjustments: $240 billion,
- Eliminating sequestration cuts: $62 billion,
- Extending and expanding telehealth services: $20 billion.

Combined, these priorities represent a total investment of $322 billion over 10 years.

Author Contributions

The article was designed by LM and MRS.

All authors contributed to the preparation of this article, reviewed and approved the content with the final version.

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References

1. 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.
2. H.R.3299 - Omnibus Reconciliation Act of 1989, P.L. 101-239, December 19, 1989.
3. S.365 - Budget Control Act of 2011, P.L. 112-25, August 2, 2011.
4. H.R.3746 – Fiscal Responsibility Act of 2023, P.L. 118-5, June 3, 2023.
5. H.J. Res 45 Statutory Pay-As-You-Go Act of 2010, P.L. 111-139, February 12, 2010.
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. 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
8. Stephenson J. Federal investigators find Medicare Advantage Plans too often deny, delay needed care. *JAMA Health Forum* 2022; 3:e221781.
9. Bohler F, Adashi EY. Addressing the marketing practices of Medicare Advantage Plans. *J Am Board Fam Med* 2024; 37:494-496.
10. Ma Y, Phelan J, Jeong KY, et al. Medicare Advantage Plans with high numbers of veterans: Enrollment, utilization, and potential wasteful spending. *Health Aff (Millwood)* 2024; 43:1508-1517.
11. Glazer J, McGuire TG. Paying Medicare Advantage Plans: To level or tilt the playing field. *J Health Econ* 2017; 56:281-291.
12. Ryan AM, Chopra Z, Meyers DJ, Fuse Brown EC, Murray RC, Williams TC. Favorable selection in Medicare Advantage is linked to inflated benchmarks and billions in overpayments to plans. *Health Aff (Millwood)* 2023; 42:1190-1197.
13. Meyers DJ, Mor V, Rahman M. Provider

DRAFT

integrated Medicare Advantage Plans are associated with differences in patterns of inpatient care. *Health Aff (Millwood)* 2020; 39:843-851.

14. Baker LC, Bundorf MK, Devlin AM, Kessler DP. Medicare Advantage Plans pay hospitals less than traditional Medicare pays. *Health Aff (Millwood)* 2016; 35:1444-1451.
15. Landon BE, Anderson TS, Curto VE, et al. Association of Medicare Advantage vs traditional Medicare with 30-day mortality among patients with acute myocardial infarction. *JAMA* 2022; 328:2126-2135.
16. H.R. 1. One Big Beautiful Bill Act. 05/20/2025.
17. H.R. 879. Medicare Patient Access and Practice Stabilization Act of 2025. 1/31/2025.
18. S.1640 - Medicare Patient Access and Practice Stabilization Act of 2025. May 7, 2025.
19. American Medical Association, Medicare Basics Series: Medicare physician payment adequacy: Budget neutrality. Accessed 06/23/2025. https://www.ama-assn.org/system/files/medicare-basics-budget-neutrality.pdf
20. American Medical Association, Medicare Basics Series: The Medicare Economic Index, June 3, 2024. Accessed 06/23/2025. https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-basics-series-medicare-economic-index
21. American Medical Association, Medicare Basics Series: Merit-based Incentive Payment System (MIPS), October 9, 2023. Accessed 06/23/2025. https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-basics-series-merit-based-incentive-payment-system
22. Manchikanti L, Sanapati MR, Pampati V, et al. A 24% decline in the utilization of epidural procedure visits for chronic spinal pain management in the Medicare population from 2019 to 2022: Updated analysis of the effect of multiple factors. *Pain Physician* 2024; 27:E983-E994.
23. Manchikanti L, Abd-Elsayed A, Kaye AD, et al. Escalating growth to rapid decline of utilization patterns of facet joint interventions in managing spinal pain in the Medicare population: Updated analysis of the effect of multiple factors from 2000 to 2022. *Pain Physician* 2024; 27:E979-E982.
24. Manchikanti L, Pampati V, Sanapati MR, et al. Exponential decline of 28.9% in utilization of interventional pain management techniques among Medicare beneficiaries from 2019 to 2022: Updated analysis on the ongoing effects of COVID-19, economic decline, the Affordable Care Act (ACA), and medical policies. *Pain Physician* 2024; 27:455-467.
25. Manchikanti L, Pampati V, Knezevic NN, et al. The influence of COVID-19 on utilization of epidural procedures in managing chronic spinal pain in the Medicare population. *Spine (Phila Pa 1976)* 2023; 48:950-961.
26. Manchikanti L, Kaye AD, Latchaw RE, et al. Impact of COVID-19 pandemic on utilization patterns of facet joint interventions in managing spinal pain in Medicare population. *Pain Ther* 2023; 12:505-527.
27. Manchikanti L, Pampati V, Sanapati MR, et al. COVID-19 pandemic reduced utilization of interventional techniques 18.7% in managing chronic pain in the Medicare population in 2020: Analysis of utilization data from 2000 to 2020. *Pain Physician* 2022; 25:223-238.
28. Wiest G, Dorius A, Bateman C, Day M. National and geographic trends in Medicare reimbursement for pain management 2014-2023. *Pain Physician* 2024; 27:E687-E693.
29. Gaffney A, Himmelstein DU, Woolhandler S. Projected effects of proposed cuts in federal Medicaid expenditures on Medicaid enrollment, uninsurance, health care, and health. *Ann Intern Med* 2025; Epub ahead of print.
30. 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.
31. 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
32. 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/
33. 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
34. 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
35. Raoof M, Ituarte PHG, Haye S, et al. Medicare Advantage: A disadvantage for complex cancer surgery patients. *J Clin Oncol* 2023; 41:1239-1249.
36. Chen XT, Glasgow AE, Habermann EE, et al. Is the rise of Medicare Advantage impacting the fidelity of traditional Medicare claims data? Implications for reporting of long-term total hip arthroplasty survivorship. *J Arthroplasty* 2024; 39:S241-S245.
37. Wang JC, Piple AS, Chen XT, et al. The rise of Medicare Advantage: Effects on total joint arthroplasty patient care and research. *J Bone Joint Surg Am* 2022; 104:2145-2152.
38. Scheffler RM, Arnold DR, Whaley CM. Consolidation trends in California's health care system: Impacts on ACA premiums and outpatient visit prices. *Health Aff (Millwood)* 2018; 37:1409-1416.
39. Health Care Cost Institute. Healthy Marketplace Index. Understanding Health Care Spending, 2021. Accessed 06/23/2025. https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Summary-Report-Current-Spending
40. Medicare Payment Advisory Commission. Report to Congress: Medicare and the Health Care Delivery System. June 2022. Accessed 06/23/2025. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v2_SEC.pdf

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