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Ending the Physician Payment Crisis: Another Reason for Major Medicare Reform

John S. O'Shea, M.D.

Under existing congressional formulas, Medicare payment rates for the services that physicians provide to Medicare beneficiaries will be reduced by 10 percent in July of this year. Instead of reforming this broken payment system, Congress will doubtless resort to another short-term fix, repeating the annual congressional fire drill to make sure that its own Medicare pricing system, featuring complex fee schedules and price controls, does not actually go into effect and wreak havoc on doctors and undercut access to care among Medicare patients.

Medicare doctors and patients will not be spared this absurd ritual until Congress replaces Medicare's existing physicians' payment system with a more rational, market-based system in which key financial decisions are made by Medicare patients. It is unlikely that Congress will undertake the program's much-needed restructuring this year, let alone before the scheduled June 2008 fee cuts. In response to the funding warning issued by the Medicare trustees, Congress has once again done nothing, even though the taxpayers have been saddled with another $2 trillion of Medicare debt since last year's trustees report.[1] Congress will have missed yet another opportunity to begin the kind of patient-centered reform that would help to bring long-term stability to Medicare.

Ever since Medicare's inception in 1966, Congress has struggled with the problem of how to pay for the escalating cost of ever-improving medical services for America's seniors. Congress has tried a number of fixes over the past four decades,[2] and all have been unsuccessful. The reason? By relying on a system of administered pricing and spending targets, congressional policy is based on the tacit assumption that government officials, rather than patients and their physicians, should decide the value of health care services. The current Medicare payment system is financially unsustainable, threatens Medicare patients' access to care, and adds to uncertainties about the adequacy of the future physician workforce.

Putting Off the Problem. For doctors, Medicare payment updates are governed by a formula called the Sustainable Growth Rate (SGR). Congress created the current methodology to adjust the payment schedule for services provided to beneficiaries by a factor that reflects cumulative spending relative to changes in the nation's gross domestic product per capita.

Each year since 2002, the SGR has called for *negative* updates to the fee schedule, and Congress has voted to defer the fee cuts without reforming the system, adding to the problem. Most recently, in December of 2007, Congress prevented mandated cuts, this time for only six months, and the issue of how Medicare will pay for physician services is again before Congress.

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Advances in medical technology, not increases in the fees that doctors charge patients, are the main drivers of the rise in Medicare spending. Spending on physician services, such as evaluation and management of common illnesses and even surgical procedures, has remained relatively flat for several years. By basing payment updates on a global spending target, the current system penalizes Medicare providers and their patients for spending that is beyond their control.

Although Congress has acted each year since 2002 to avert the scheduled negative updates to the physician fee schedule, the SGR formula mandates that payment for services provided to Medicare beneficiaries be cut by as much as 35 percent to 40 percent by 2016.[3] This will force a majority of physicians to reduce the number of Medicare patients they treat and will inhibit investment in health information technology and other quality improvement measures, according to recent surveys.[4] In addition, the current system does not reward physicians who provide better-quality, more efficient services.

The Challenge to Change. Congress should take this opportunity to avoid seriously undermining access to care for seniors in the short term and should begin to ensure the long-term stability of the Medicare program by introducing concrete measures that are centered on restoring financial control to patients. Specifically, Congress should:

- **Prevent the scheduled fee cuts.** Allowing the scheduled fee cuts will result in a significant reduction in access to health care for America's seniors and therefore is not an option. In addition to the threat of significant cuts in Medicare payments, physicians face mounting practice costs and steep payment decreases from private insurers.

  Medicare beneficiaries have already begun to report difficulty in scheduling timely appointments, especially with primary care providers, and if the current cuts go into effect, this problem will be greatly exacerbated. Congress should replace the scheduled cuts with a 1.8 percent increase for the next 18 months, both to offset the increase in medical practice costs and to allow Congress time to initiate real reform of the Medicare payment system.
- **Repeal the SGR.** MedPAC, the American Medical Association, medical specialty organizations, and most prominent health policy analysts have been calling for repeal of the SGR for a number of years.[5] At the very least, given the legislative reluctance to abandon administrative pricing and spending targets completely, and given the need to restrain the unsustainable future cost of Medicare, Congress should replace the SGR with a more stable measure and allow physicians to balance-bill for their services.

  The measure that replaces the SGR as the standard for payment updates should be stable and predictable. The best approach is to update the physician payment schedule based on a more conscious long-term budget for Medicare together with an annual market survey by MedPAC of the market costs of providing medical services. Such a survey would offer a measurement of relevant costs in the medical market. Medicare payment rates could then more accu-

1. Greg D'Angelo and Robert E. Moffit, Ph.D., "Congress Must Not Ignore the Medicare Trustees' Warning," Heritage Foundation *WebMemo* No. 1869, March 27, 2008, at *http://www.heritage.org/research/healthcare/wm1869.cfm.*
2. For a detailed discussion of the evolution of the Medicare Physician Payment System, see John S. O'Shea, "The Urgent Need to Reform Medicare's Physician Payment System," Heritage Foundation Backgrounder No. 1986, December 5, 2006, at *http://www.heritage.org/Research/HealthCare/bg1986.cfm.*
3. D. B. Marron, Congressional Budget Office, "Medicare's Physician Payment Rates and the Sustainable Growth Rate," testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, July 25, 2006.
4. American Medical Association, "2006 AMA Member Connect Physician Survey: Physicians' Reactions to the Projected Medicare Payment Cuts," at *www.ama-assn.org/ama1/x-ama/upload/mm/468/medicarepaymentmc.pdf.*
5. G. M. Hackbarth, Medicare Advisory Commission, "Report to the Congress: Medicare Payment Policy," testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 11, 2008.

rately reflect the pre-established rate of return to physicians necessary to achieve an acceptable level of availability and quality of services within the desired Medicare budget. Because it is an annual survey, it would also be flexible, allowing for shifts in relative costs and prices, technologies, and specialties and practices, some of which would be influenced over time by the payment rates themselves.

Such a regularly updated payment schedule is far preferable to a rigid SGR or other schedule based on past practices and updated either on an *ad hoc* basis or on some index such as the Consumer Price Index that fails to reflect current changes in the medical marketplace.

- **Promote self-sufficiency and accountability among doctors in traditional Medicare.** Congress should remove restrictions on balance-billing. Doctors should be able to determine their own success based on their performance, not on government pricing decisions. In traditional Medicare, quality-improvement efforts tend to be disaggregated and often measure processes during an episode of care. Although these measures may provide feedback to help physicians improve care, patients are more concerned about the outcome following an interaction with the health care system.

  For traditional Medicare, Congress should increase support for projects that help the medical profession develop a coordinated, outcomes-based quality measurement and improvement system that will collect and report data on health outcomes, coordination of care, use of Health Information Technology (HIT), patient satisfaction, and spending, allowing a more transparent, provider-specific analysis of the value of services.
- **Start moving to a new patient-centered, consumer-driven system based on a defined contribution in Medicare.** New Medicare beneficiaries should have the option of receiving a defined contribution that can be used to purchase the coverage plan that they feel is most appropriate to their situation, similar to the option Members of Congress and other federal employees enjoy in the Federal Employees Health Benefits Program (FEHBP). This would eliminate the need for the centralized price administration that governs Medicare today and give beneficiaries control of their health care resources, shifting the decision over which plans and benefits will be covered from government to the individual.

  It also would promote competition among plans as well as providers. Informed patients, along with their physicians, are better situated to decide the value of coverage and services according to their own individual and clinical situations. If patients are willing to pay for discretionary services or for a doctor or medical specialist who has been shown to have better outcomes, they should be able to do so.

Conclusion. Unless Congress intervenes, Medicare payments for physician services will be cut by 10 percent in July of this year. Congress needs to prevent these cuts in order to avoid jeopardizing access to care for America's seniors.

Major reform of the Medicare payment system that is centered on the patient can no longer be postponed. This reform should begin by replacing the SGR with a more rational methodology. At the same time, Medicare needs to start moving to a system that gives beneficiaries a defined contribution, with the option of ownership and control of their health care resources. Such a reform would give providers self-sufficiency while insisting on greater accountability.

The sooner Congress starts this process, the easier it will be for Medicare beneficiaries, taxpayers, and Congress itself.

—John S. O'Shea, M.D., is a practicing physician and a former Health Policy Fellow at The Heritage Foundation.