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Fixing Medicare's Physician Payment System

Bruce C. Vladeck, Ph.D.

Now that Congress has completed the epochal, exhausting, and contentious task of enacting comprehensive health care reform, it must confront another health care issue that is perhaps even more politically difficult: reform of Medicare's physician payment system. On April 15, Congress voted to postpone a 21% reduction in Medicare fees that was to have gone into effect April 1, but a longer-term solution is not yet in sight.

The problems with the Medicare physician payment system are twofold, and each dimension poses complex political difficulties. First, Medicare is captive to an arbitrary, if elegantly conceived, formula for total payments to physicians — the sustainable growth rate (SGR). In the alternate reality of the Congressional budget process, the SGR will reduce Medicare's physician payments, which already trail those from private insurers, as far into the future as the eye can see. Second, there is widespread consensus that the relative fees in the current system are a significant cause of the growing imbalance in supply and utilization between primary care and specialty services in the U.S. health care system. That imbalance, in turn, is widely perceived as a major cause of both excessive costs and inadequate quality of care. This is not just a Medicare problem: the Medicare Resource-Based Relative Value Scale is used by most private insurers to set relative prices for physicians.

In 1997, when Congress refined the formula by which the annual change in Medicare physician fees was determined, it decided that total physician payments per beneficiary should grow no faster than the economy as a whole, as measured by the gross domestic product (GDP). Policymakers were concerned about increases in the volume of services that beneficiaries received; since total spending equals price times volume, under an aggregate cap, if volume grew more quickly, fees would grow more slowly or be reduced.[1] The expectation that total physician spending could be kept to such a level was probably unrealistic, since few countries have ever attained that target, and an increasing proportion of health care services were migrating from inpatient hospitals to the lower-cost settings of outpatient facilities and physicians' offices, which many thought would improve outcomes and save money. But the economy was growing robustly, and the SGR's framers were pursuing a broader agenda of trying to drive the entire Medicare system away from fee for service toward private, capitated plans.

Moreover, the excessively ambitious growth target is only the beginning of the problem. The SGR is a cumulative, prospective formula; if actual spending in a given year exceeds that year's target, the following year's spending is supposed to be reduced proportionately, but if that reduction is insufficient, then additional reductions must come in the future. Every time Congress postpones a formula-determined fee reduction, it compounds the difference between actual and expected fees, making the (theoretical) eventual adjustment that much more severe. Thus, since the SGR was implemented in 1998, total Medicare physician expenditures have exceeded the allowed amounts by only $20 billion (on a total of almost $1 trillion), but to recoup that all in 1 year would require a 21% reduction in 1 year's fees. And those reduced fees would then become the base for payment levels in all subsequent years.[2]

In a rational world, Congress would write off the $20 billion

as a relatively small policy error and establish a more realistic prospective formula. But under Congressional budget rules, the cost of doing so is not $20 billion, but $20 billion per year, compounded by inflation, times 10 years. The Congressional Budget Office and the Office of Management and Budget are required to assume that someday Medicare's physician fees will be permanently lowered to SGR levels and that anything above that amount is "extra spending."

Of course, even $250 billion over 10 years is a rounding error relative to an annual deficit of $7 trillion, but elected officials, while steering every nickel they can to their constituents or contributors, like to pose as sworn opponents of deficit spending. Out of context, $250 billion certainly seems like a lot of money, and in today's U.S. Senate, it takes only a handful of politicians to bring the legislative gears to a halt. In fact, early last year, the House of Representatives passed legislation that would have changed the budget rules to permit a more sensible fix for the SGR, but the proposal died in committee in the Senate.

The country's long-term budgetary status is a serious problem, and budget discipline has to begin somewhere. But everyone seems to agree that reducing Medicare's physician fees by 21%, in perpetuity, while private fees continue to increase might create access problems for at least some beneficiaries and might harm providers whose high volume of service to Medicare beneficiaries leaves them especially dependent on Medicare revenues.

As if that weren't problematic enough, the basic mechanics of the Medicare Physician Fee Schedule, which was supposed to change physician payment to increase rewards for primary care services at the expense of procedural and interventional services, appears to have gone totally off track. For various reasons, the fee schedule, which originally did increase the prices of evaluation and management services relative to those of surgery or invasive procedures, turned in the other direction through the process of annual updating of relative value units.[3] Surgeons, radiologists, and some medical specialists are now paid two to three times as much per hour as providers of cognitive services, which is about where we began 20 years ago; this was the situation that the fee schedule was supposed to fix.

The question of the relative virtues of primary versus specialty care can be debated ad nauseam, but in other wealthy countries that serve their populations at least as well as we do, the ratio of primary care physicians to specialists is much higher than in the United States, and the gap in compensation is much smaller or the poles even reversed.[4] Young physicians, burdened by increasing educational debts, may well choose a career path on the basis of a major difference in compensation, especially when the better-compensated positions require less ongoing responsibility for patients and offer better working hours.

Under a budget constraint, however, changes to the relative fees paid to various categories of physicians give rise to zero-sum "distributional politics"; there may be a theoretically correct way to determine relative fees, but that is largely irrelevant to a legislative process in which various groups are free to pursue their self-interests. The only general solution to such a political free-for-all is to increase the total pot available for distribution — as is customarily done, for instance, in the realm of agricultural policy. Last year's House-passed health care reform bill took this approach, and the final reform law does add a modest amount of money to primary care fees.

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But here the two dimensions of the problem intersect. The way to redress the imbalance between primary care and specialty compensation while shrinking the disparity between Medicare and private insurance is to add more money to primary care while leaving specialists' fees unchanged, on average. But doing so worsens the

federal deficit, providing fodder for those who pose, at least, as opponents of deficit spending. And then the pundits argue that fixing the current system isn't really worth the bother — that fee-for-service payments are so intrinsically counterproductive that we should just scrap them in favor of something better.[5] Except that no one knows what that something is.

The enactment of health care reform after many considered it irreversibly derailed by the Senate election in Massachusetts has suggested to some that perhaps the U.S. political system is not so hopelessly gridlocked after all. Health care reform, some believe, might be a harbinger of a more sensible and productive approach to solving serious policy problems. Untying the political knots enmeshing Medicare physician payment will test that optimism.

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