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Health Policy Brief

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Paying Physicians For Medicare Services.

It is widely agreed that the existing payment system is broken. Congress has again enacted a short-term fix to a long-term problem that it must soon revisit.

WHAT'S THE ISSUE?

Congress has voted to halt and delay until December 31, 2010, a 23 percent reduction in physician fees under Medicare that had been slated to take effect December 1. But this short-term fix does not address an additional 1.9 percent cut scheduled for January 1, 2011. Unless Congress acts on both measures before the end of the year, physicians will face a 24.9 percent cut in Medicare fees starting January 1. This latest episode represents the fifth time this year that scheduled Medicare fee cuts to physicians have been averted at the last moment—or even later. Members of Congress are working on plans to put off physician pay cuts for the rest of 2011. A longer-term repair is needed, but it will be costly for US taxpayers, and is likely to remain a pressing issue for the incoming 112th Congress in January.

WHAT'S THE BACKGROUND?

There is widespread agreement that the existing system of paying for physician services under the Medicare program is broken. According to current Medicare rules, which are intended to restrain growth in spending, payments to physicians have been subject to supposedly “automatic” cuts for a number of years. However, Congress has consistently postponed those cuts and instead raised physician fees or held them constant.

The latest scheduled cut for physician fees was a 23 percent reduction set to go into effect on December 1, 2010. On November 18, 2010, the Senate approved, by unanimous consent, a bill to postpone the cut until December 31, 2010 (HR 5712). The House of Representatives approved the measure by voice vote on November 29, 2010. President Barack Obama signed it into law on November 30.

A permanent “doc fix” that would override both pending and expected automatic cuts in future years would add \$330 billion to federal spending over the next decade, according to the Congressional Budget Office (CBO). There is no agreement in Congress on how best to make the fix or on how to pay for it, whether by raising taxes, cutting other federal spending, or simply adding the amount to the federal deficit. This brief describes the likely options for congressional action in the months and years ahead.

COMPLEX SYSTEM: Medicare pays physicians using what is called a fee schedule, or list of prices. This list sets a fixed maximum price for each type of service, such as an office visit, a particular surgical procedure, or a specific diagnostic test. Current law requires the Centers for Medicare and Medicaid Services (CMS) to update these prices each year.

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When computing the annual update, CMS starts with an estimate of inflation but then adjusts this amount upward or downward, depending on how rapidly overall spending for physician services has been growing. If spending has stayed within set targets, physicians get a bonus—a price increase greater than inflation. But if spending has exceeded the targets, the updated prices may rise more slowly than inflation or even be reduced.

The current system of spending targets was put into place by the Balanced Budget Act of 1997. The aim was to give physicians an incentive to restrain the growth in the number of services they furnished to patients, and to discourage them from providing higher-price services in place of lower-price ones.

The spending targets are set using a “sustainable growth rate” formula, often referred to as the SGR. The formula is complicated, but its basic goal is to keep spending for each beneficiary from growing faster than the per capita increase in the gross domestic product (GDP). GDP growth is included in the formula on the theory that it is not sustainable for Medicare physician spending to grow faster than the national economy.

HOPE NOT REALIZED: The expectation that this payment system would control spending was not realized. In the first few years under the 1997 rules, physician spending did stay within the targets, and physicians were rewarded with price increases greater than inflation. For 2002, however, the update

formula in the law required a reduction in physician fees of almost 5 percent. Congress allowed the reduction to take effect. But when the formula dictated a further reduction for 2003, Congress overrode the Balanced Budget Act rules and approved a small fee increase.

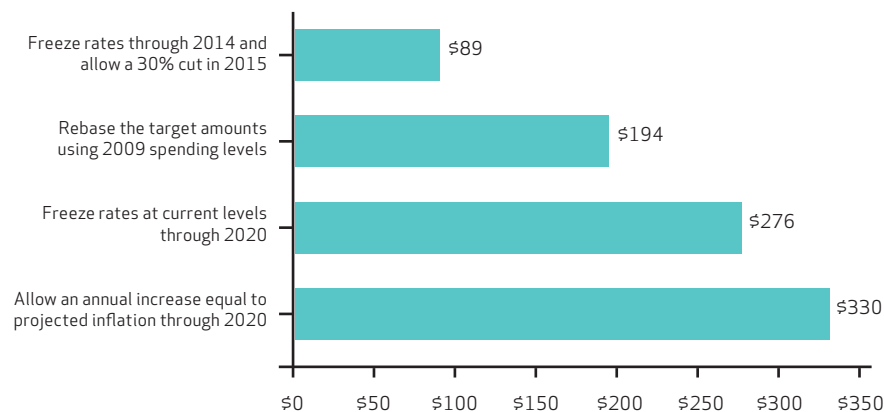
That action set a precedent that has continued to this day. In each year since 2003, although the statutory formula would have led to a fee cut, Congress has instead granted an increase or at least frozen the rates and prevented a decrease.

FORMULAS UNCHANGED: Although Congress has repeatedly intervened to prevent rate cuts, it has never changed the formulas that dictate these cuts. Each time it has set the fee increase, Congress has specified that fee updates for later years should be computed as if it had not acted. What’s more, Congress has never modified the SGR targets themselves.

Meanwhile, the number of services that physicians provide has been growing steadily, and the services are increasingly costly and complicated. That means that there has been a widening gap between actual spending each year and the amount allowed by the targets. Under the law, this ballooning deficit is supposed to be recouped by even steeper automatic rate cuts in the future. But so far, Congress has acted systematically to forestall the cuts, and even to grant physicians small Medicare fee increases.

EXHIBIT 1

Increase in Net Federal Outlays under Different Proposed Changes in Medicare Physician Payment



\$89 billion

Federal deficit increase

The estimated increase to the federal deficit if Medicare physician payment rates were frozen through 2014.

“The expectation that this payment system would control spending was not realized.”

SHORT-TERM ACTIONS: Why has Congress consistently acted in this “Perils of Pauline” fashion, overriding automatic cuts on a short-term basis 10 times so far? The answer is that a longer-range fix could greatly increase the federal deficit. Congress relies on the CBO to measure the budgetary impact of proposed legislation. The CBO establishes a “baseline,” projections of future spending and revenues that assume all current laws will be enforced. The baseline includes all of the physician cuts scheduled to take effect in future years, which will produce substantial savings for Medicare.

As a result, legislation that overrides future cuts would be “scored” by the CBO as increasing the deficit, in contrast with the current baseline. Eliminating the SGR targets and allowing Medicare physician fees to be increased annually for inflation would cost \$330 billion between 2011 and 2020.

Postponing the cuts month by month or year by year, as Congress has done, has a smaller apparent budgetary impact. Yet even the six-month rate increase passed by the House and Senate in June 2010 was scored as costing more than \$6 billion, although the bill included savings provisions to offset that amount. The recently enacted one-month extension costs another \$1 billion. It is to be offset by reducing payments for multiple outpatient occupational, physical, and other therapy services provided to Medicare patients on the same day.

Few members of Congress wish to see physician payments slashed, and many would prefer to see some permanent fix so that they would not have to revisit the issue. Yet there are also mounting concerns about the overall size of the future federal deficit. In this context, many members on both sides of the aisle are reluctant to enact a costly fix without finding some way of paying for it.

WHAT ARE THE LONGER-RANGE OPTIONS?

Now that another short-term fix has been passed, Congress has several longer-range options. It could do nothing and let future cuts take effect. It could drop the SGR system and simply freeze future rates or let them rise with inflation. It could keep the current system but adopt various proposed modifications. It could adopt other fee schedule changes that might help slow spending growth. Or it could develop entirely new ways of paying for physician services.

DO NOTHING: Congress could simply allow scheduled fee reductions to take effect. Without a fix, physician payments would drop as much as 40 percent from 2009 levels over the next several years. Although the government would save money, there are concerns about the potential impact that such large cuts would have on Medicare beneficiaries’ access to health care. If Medicare rates fall too far behind those paid by private insurers, physicians might turn away current Medicare patients or stop accepting new ones. That would be more likely to happen if physicians have enough non-Medicare patients to make up for the income losses. The best guess is that physicians’ ability to replace Medicare patients with those who have private insurance is likely to vary by geographic area and physician specialty.

Another possibility is that physicians would make up for lower Medicare fees by increasing the volume or intensity of services furnished to Medicare beneficiaries. However, it is unlikely that such “behavioral” changes could offset a 40 percent fee cut.

Whatever the potential effects of rate cuts might be, some people contend that the entire SGR approach has proved unworkable. The SGR system was supposed to give physicians incentives to practice more efficiently and thus gain higher fee increases, or at least avoid decreases. But the incentives don’t work for individual physicians.

The problem is that if some doctors provide extra services, they will make more money in the short term than those who don’t—yet the resulting penalties fall on everyone. Because of these perverse incentives, critics contend, aggregate spending targets may never be workable and should be replaced by more focused cost containment methods.

ABANDON THE SUSTAINABLE GROWTH RATE SYSTEM: Congress could decide to eliminate the formula that ties fee updates to trends in spending growth. Those who favor this step argue that since Congress is unlikely ever to allow the full scheduled rate cuts, it would be better and arguably more honest to take the full budgetary hit at once, instead of year by year. With no system in place for updating the fee schedule, Congress might at some point come up with a better approach.

A contrary view is that repeated short-term fixes to the SGR system are actually preferable. If the threat of rate cuts were permanently

-40%

Medicare rate reduction

The scheduled reduction in Medicare rates by 2014, unless the law is changed.

“Long-range savings will require other reforms in the current payment system.”

removed, Congress would never get around to fixing the system.

Others have suggested shelving the problem for some years, rather than a few months at a time, in the hope that additional breathing room would make it possible to develop a consensus around more comprehensive reforms in the system. But even that kind of half-measure would cost a great deal. For example, the CBO estimates that freezing the rates through 2014 would raise the deficit by \$89 billion.

MAKE LONG-TERM MODIFICATIONS TO THE SGR SYSTEM: There are numerous proposals on the table to continue the current system of SGR targets, but with various modifications. CMS could simply wipe the slate clean and base future targets on actual current spending levels. In effect, past overspending would be forgiven, offering physicians a new chance to restrain spending but threatening them with penalties in the future if they failed to do so.

This approach, known as “rebasings,” would be almost as costly as getting rid of the targets altogether. And rebasing would not correct the distorted incentives in the current system. Over time, physicians might once again ramp up service delivery until the formula dictated rate reductions.

Other options include setting separate spending targets for different services, different geographic areas, or even specific providers or groups of providers. For example, Congress could allow more spending growth in services such as primary and preventive care, while clamping down on such fast-growing areas as x-rays and other imaging services.

Another approach might be to establish separate targets for areas with lower and higher average per capita spending. Physicians in some areas deliver or order far more services for Medicare beneficiaries than do physicians in other areas, and there is little evidence that patients in high-volume areas have better health outcomes. Geographically based targets would focus on constraining spending in high-cost areas.

Although these options are more focused than the current system, there is still a risk that they would penalize some efficient providers or reward some inefficient ones. To prevent this, updates or targets could be set for specific providers.

Under one proposal, CMS could identify physicians who provide or order an unusually high number of services and could reduce fee updates for those who fail to change their behavior. Any such option would be controversial. It would require extensive data and some consensus on how to distinguish inefficient providers from those who are treating difficult cases.

Finally, payment targets could be broadened to include a wider scope of services. The Medicare Payment Advisory Commission (MedPAC) has suggested that if payment targets are retained, they should apply to all health care sectors. MedPAC notes: “Medicare has a total cost problem, not just a physician cost problem.” In this scenario, systemwide targets could pressure physicians, hospitals, and others to collaborate in order to reduce unnecessary or duplicative services.

MAKE OTHER PAYMENT REFORMS: Whatever happens to the SGR targets, long-range savings will require other reforms in the current payment system. Incentives for physicians are driven not just by the overall level of Medicare prices, but also by the prices for specific services. MedPAC and others have contended that certain services are “overvalued”: The price is too high relative to the difficulty of providing the service or the physician’s overhead costs.

Because overvalued services can be profitable, physicians have incentives to furnish more of them, while the system discourages the delivery of primary care and other undervalued services. Over time, misaligned incentives can even affect career choices, driving physicians into specialties with the most profitable services. CMS has been taking action on its own to correct some of these pricing problems, and further changes are mandated in the new health reform law.

Many observers argue that Medicare needs to move beyond the basic idea of paying physicians for each service that they provide to each patient. Paying service by service may encourage the fragmentation of care and the delivery of unnecessary services.

There are numerous proposals for payment changes that would promote integrated care delivery and encourage cost-effective medical treatment. One option is the bundled payment, a single payment to a provider for all services related to a specific disease or condition during some fixed period. Another is to encourage the development of accountable

care organizations (ACOs), networks of physicians and other providers that would accept responsibility for the overall care of a population of Medicare patients, perhaps in return for a fixed per capita payment.

Many people think these approaches could eventually yield real savings. Still, it could take many years for CMS to develop new payment systems and for providers to form the organizations that can receive the payments. In the interim, most Medicare physician services will still be paid on a fee-for-service basis. And Congress will still face the task of balancing budgetary concerns with the goal of maintaining access to high-quality care for Medicare beneficiaries.

WHAT'S NEXT?

Because the one-month extension has now been signed into law, Congress would have to revisit the issue before January 1, 2011 to prevent the scheduled 23 percent cut and an

additional 1.9 percent reduction from taking effect. The White House, congressional leaders, physicians, and patient groups hope that a more permanent solution can be found.

Senate Finance Committee Chairman Max Baucus (D-MT) and ranking Republican member Charles E. Grassley (R-IA) are working on a one-year Medicare pay extension for all of 2011 that would cost about \$17 billion to fund. House leaders have introduced a separate bill that would extend payments by 13 months and provide a 1 percent increase through the end of 2011. That bill would cost \$17–\$20 billion.

It is not clear if or when either measure will be acted on in Congress. Even if agreement is struck on a one-year fix, given the costs and concerns about federal budget deficits, finding a more permanent solution for the flawed physician payment formula under Medicare is likely to preoccupy policy makers for the indefinite future. ■

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