

How Will Physicians Be Affected by Health Care Reform?

Timely Analysis of Immediate Health Policy Issues

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The coverage expansions that are at the center of health care reform will likely boost practice revenues for many physicians.¹ In addition, provisions that require an increase in fees paid for primary care in Medicaid and Medicare will also benefit some physicians.² However, those aspects of health reform that are included as part of the effort to make the system more efficient and less costly could have financial consequences that would not be welcomed by many physicians. These include accountable care organizations (ACOs), bundling Medicare payments, creating an Independent Payment Advisory Board (IPAB), and sponsoring comparative effectiveness research.

Coverage Expansions

Although there are a number of specific provisions related to physician payment and practice organization in the health reform law (discussed below), the biggest impact of the reforms will likely come from the substantial reduction in the number of people without health insurance. As a result of adding more than 30 million insured people to the population, it is likely that the demand for free or reduced-cost care will go down and this should have a positive impact on physician practice revenues and incomes. Survey data show that the share of physicians providing free or reduced-cost care has been declining since the 1990s, but from 2004 to 2005, almost 70 percent of physicians provided some of this

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care.³ These physicians will clearly benefit from a reduction in the numbers of uninsured.

However, even physicians who never provided free or reduced-fee care could benefit from the coverage expansion. There will be more people who will be able to make an appointment with a physician and present an insurance card as evidence that care will be compensated. Some physicians may be happy with their current caseloads and will not accept additional patients. However, many other physicians—primary care physicians as well as specialists—will see their practices grow and their incomes rise. As the coverage expansion affects patient demand, it is likely that some physicians will benefit financially and some will be unaffected, but virtually none will be disadvantaged.

One way that the number of uninsured Americans will be reduced will be by a major expansion in Medicaid coverage. The bulk of the people who will be covered by Medicaid are those who would otherwise have been uninsured. Therefore, even though Medicaid has the lowest fees in most areas,⁴ physicians choosing to treat these patients do so knowing that they will be paid something as opposed to running the risk of not getting paid

anything from a low-income uninsured patient. The only real way that a physician would be adversely affected by reform would be if a substantial share of a physician's patients shifted from private coverage to Medicaid, resulting in a major reduction in the average fees the physician receives.

Promoting Primary Care Physician Services

Policymakers recognized that Medicaid has had the lowest physician payment rates within the U.S. health care system and that many physicians were reluctant to treat Medicaid patients in their practices. To try to overcome these potential access barriers, at least for primary care physicians, the health reform law will raise Medicaid fees for primary care services provided in 2013 and 2014 by family practitioners, general internists, and pediatricians to Medicare-fee levels. Although the ratio of Medicaid to Medicare fees varies considerably across states, on average, Medicaid fees for primary care services were about two-thirds of those set by Medicare in 2008.⁵

The federal government will pay the entire incremental cost of this provision, and the Congressional Budget Office (CBO) estimates that



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the cost will be \$8.3 billion. This includes expenditures during 2013 and 2014 as well as the next four years, suggesting that CBO is allowing for a tail in claims processing or, more likely, that some states will not immediately roll back their Medicaid fees for primary care. It is quite likely that, once primary care fees are increased to the extent that this policy calls for, it may be difficult to implement the “cut” that would be implied by a return to current payment levels.

Since there are reasons besides low Medicaid fees that may lead some physicians to choose not to treat Medicaid patients, these fee increases are not likely to result in the same high levels of access currently experienced by Medicare patients.⁶ In addition, the Medicaid fee increases will only relate to a subset of services and a subgroup of physicians. Specifically, fees for specialty care will not be affected and access barriers that Medicaid enrollees and the uninsured face when needing specialty care are likely to persist.

The Medicaid fee changes are not the only attempt within health care reform to improve payments for primary care. Medicare fees for primary care services provided by some family practitioners, internists, geriatricians, pediatricians, nurse practitioners, clinical nurse specialists, and physician assistants will be increased by 10 percent between 2011 and 2015. In order to qualify for the bonus, the physician or the practitioner needs to have had primary care services account for at least 60 percent of their allowed charges in a prior period (as yet to be established). There will also be a 10 percent bonus paid to general surgeons between 2011 and 2015 if they provide major surgical procedures in health professional shortage areas. Although these Medicare bonus payments will be in

effect for twice as many years as the Medicaid fee increases, they involve a considerably smaller outlay of federal spending, accounting for only \$3.5 billion. One reason for this is that the Medicare bonus is smaller than the average Medicaid increase. In addition, fewer providers will be affected by the Medicare bonus than by the Medicaid add-on, especially in 2014, when Medicaid eligibility expands.

The health reform law tries to further promote primary care by funding (\$1.5 billion) the National Health Services Corps to get more physicians into health professional shortage areas. There is also a provision that will allow unused residency slots to be shifted to programs that train primary care physicians and general surgeons.

Accountable Care Organizations

Efforts to bend the cost curve included in health reform are also likely to affect physicians, but in ways that are hard to determine in advance. One provision would encourage physician and hospitals to organize accountable care organizations that are intended to develop approaches to providing high quality care at low costs.⁷ Any Medicare savings that emerge from these ACOs would be shared with the providers. Although many details of this policy need to be worked out, CBO projected that Medicare would save \$4.9 billion as a result of this provision. This implies that payments to providers in ACOs would be less than they otherwise would have been under fee-for-service (FFS) Medicare. But, the distribution of revenues might shift from hospitals to physicians. One of the aspects of ACOs that make them hard to analyze is that providers would only be required to form ACOs on a voluntary basis. Therefore, if physicians are doing well under current FFS

arrangements, it may be hard to get many of them—in particular, specialists—to join in the ACO effort.

Bundling Medicare Payments

Another provision that could affect physicians is one that creates a national pilot program on payment bundling in Medicare. Under this pilot program, a payment would be made for all services provided during an episode of care and not for individual services. The goal would be to promote efficiency while maintaining or improving quality. Alternative approaches could be tested in different areas and, if successful, could be expanded nationally. Based on the available evidence, CBO was not willing to assume that this policy change would result in any savings.

Independent Payment Advisory Board (IPAB)

Beginning in 2014, in any year in which the Medicare *per capita* growth rate exceeded a target growth rate, the IPAB would be required to recommend Medicare spending reductions. The recommendations would become law unless Congress passed an alternative proposal that achieved the same level of budgetary savings. This body could have considerable power over some Medicare payment rates. However, at least initially, the IPAB’s influence may be limited because some provider groups are exempted—importantly hospitals and certain other provider types that experienced significant reductions in their market basket updates in the legislation—until 2020. Although physicians are not excluded, there are no silver bullets here. Congress has been unwilling to exact any cuts in fees to physicians under the SGR policy except for 2002. The Medicare Payment Advisory Commission (MedPAC) has not found a practical alternative to the SGR that

would be more palatable while producing savings. So it is not clear what IPAB could do that the Centers for Medicare and Medicaid Services (CMS) is not doing through the rule-making process to reduce overpriced services or through new organizational and payment models that are part of the legislation, such as by promoting ACOs.

All of this comes at a time when it is possible that there will be significant access problems for Medicare (and by extension Medicaid, even if fees are tied to Medicare for primary care) as these fees lag further behind commercial insurer fees schedules and, perhaps as important, what physicians can charge by direct or balanced billing to patients. To the extent that CMS, MedPAC, or IPAB want to take on the FFS mispricing that inappropriately favors tests, imaging, and many procedures, certain specialists will be losers—mostly radiologists and nonsurgical proceduralists, whereas primary care physicians, psychiatrists, internal medicine subspecialties and even some surgical specialties will be winners.⁸

Comparative Effectiveness Research (CER)

The impact that CER will have on physicians will depend very much on how any results are used by physicians, patients and payers. More CER should significantly improve physician decision-making on behalf of their patients. On revenues, the probable impact will be mixed. Physicians doing procedures or tests of little or no benefit will have these services identified and that should produce fewer requests for services—whether by physicians themselves refraining from providing these services, fewer referrals to or from other physicians, or more information to allow patients to become better shoppers. The mix of these responses will likely vary by service. There could and should be some reduction in FFS payments to some physicians.

Overall, there is some reason to believe that CER would negatively affect specialists more than primary care physicians because much more of the former's income comes from tests, procedures, and imaging—which would be the most studied CER topics. The key to the potential cost

savings will be whether CMS and other payers ever formally use the results of CER to make coverage and payment determinations. So far that issue is not addressed in legislation—what legislation that exists limits CMS discretion in this area.

Conclusion

Although physicians understandably have been focused on the sustainable growth rate policy and its potential for large Medicare fee cuts, many may benefit from the key provisions of health care reform. Expansions in insurance coverage and increases in fees for primary care services will have direct benefits on practice revenues for large numbers of physicians. The likely effects of efforts to bend the cost curve that can affect physicians—ACOs, bundled payments, IPAB, and CER—are less clear. But, if they succeed in producing a more efficient health care system, physicians could gain relative to other providers and, among physicians, primary care physicians could gain relative to specialists.

Notes

¹ A summary of the new health reform law is available at <http://www.kff.org/healthreform/8061.cfm> (Kaiser Commission on Medicaid and the Uninsured).

² This brief is written under the assumption that any fee cuts required under the Medicare Sustainable Growth Rate (SGR) policy will not go into effect as a result of congressional action. Since the Balanced Budget Act of 1997, Medicare has had a policy that would set physician fee updates based on spending growth being above or below a target for FFS Medicare physician spending. The target is based on the growth in GDP, the number of FFS beneficiaries and the prices of practice inputs as well as changes in laws and regulations. Since 2002, when the SGR policy led to a 4.8 percent reduction in the Medicare physician fee schedule conversion factor, Congress has been searching for ways to avoid fee reductions without adding to program expenditures. Each year, physicians have received small fee increases and Congress has implemented a range of policy changes to offset the costs of circumventing the SGR policy. As of April 1, fees were scheduled to be cut by 21 percent, but Medicare has instructed bill processors to hold all claims until Congress can legislate so that the cuts do not go into effect. Some hoped to end this constant need to circumvent the SGR policy as part of health reform, but that did not occur. The primary reason that a permanent end to the SGR policy is hard to implement is that, relative to the fee cuts that are reflected in a baseline that includes the SGR, even a policy that had very modest or no fee increases would add roughly \$200 billion to Medicare spending over the next decade.

³ Cunningham P and May J, *Medicaid Patients Increasingly Concentrated Among Physicians*. Tracking Report No. 16. Center for Studying Health System Change, August 2006, available at <http://www.hschange.com/CONTENT/866/>.

⁴ Zuckerman S, Williams A and Stockley K, "Trends in Medicaid Physician Fees, 2003-2008," *Health Affairs*, 28, no. 3 (2009): w510-w519, April 2009.

⁵ Zuckerman et al., *Health Affairs*, April 2009.

⁶ See, for example, Cunningham P and O'Malley A, "Do Reimbursement Delays Discourage Medicaid Participation by Physicians?" *Health Affairs*, 28, no. 1 (2009): w17-w28.

⁷ Devers K and Berenson R, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?*, Urban Institute Policy Brief, October 2009.

⁸ Berenson R, Zuckerman S, Stockley K, Nath R, Gans D and Hammons T, *What if All Physician Services Were Paid Under the Medicare Fee Schedule? An Analysis Using Medical Group Management Association Data*, MedPAC Contractors Report, March 2010, http://www.medpac.gov/documents/Mar10_Physician_FeeSchedule_CONTRACTOR_v2.pdf.

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