

HealthAffairs

Robert Wood Johnson Foundation



# Health Policy Brief

UPDATED: FEBRUARY 13, 2013

## Medicare Payments to Physicians. After enacting another short-term ‘doc fix,’ Congress may finally have a permanent solution in its sights.

### WHAT'S THE ISSUE?

A problematic formula for paying physicians under Medicare has been in place for years and, since 2003, has been stipulating that there should be mandatory cuts in payments to doctors as a result of the increasing volume of services provided. However, Congress has consistently postponed those cuts and instead raised Medicare physician fees slightly or held them constant.

In early January 2013, Congress adopted and President Barack Obama signed legislation to postpone a scheduled 26.5 percent reduction in Medicare physician fees and keep rates unchanged until January 1, 2014. In February 2013, the Congressional Budget Office (CBO) issued new estimates of the cost of this “doc fix” that greatly increased the likelihood of congressional action making the change permanent.

This policy brief examines the various proposals and their possible effects on federal spending and on health care providers.

### WHAT'S THE BACKGROUND?

Medicare pays physicians using a fee schedule, or list of prices. This list sets a fixed maximum price for each of more than 7,000 defined services, 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—using a formula that, in theory, ensures that total per capita spending for physician services does not grow faster than the increase in the gross domestic product (GDP).

**TARGETING SPENDING:** The formula has its roots in concerns dating back to the 1980s about the rapid rate of growth in the number of services that physicians were providing to their Medicare patients. In 1989 Congress put in place a fee schedule system and a method for annually updating fees that was intended to slow growth in volume. In 1997 Congress revisited this approach and put in place a system of spending targets based on a “sustainable growth rate” formula, often referred to as the SGR.

Here is how the system works: When computing the annual update, CMS starts with an estimate of inflation in the costs of running a medical practice. It then adjusts this amount upward or downward, depending on how rapidly total Medicare spending for services rendered by physicians (and some related services) has been growing. If spending has stayed within set targets, physicians get a bonus—a payment increase greater than inflation. But if spending has exceeded the targets, the updated prices may rise more slowly than inflation or even be reduced.

# 26.5%

**Physician payment reduction**  
Unless Congress had intervened, Medicare payment rates would have been reduced by 26.5 percent starting January 1, 2013.

**“The expectation that this payment system would control spending has not been realized.”**

The SGR formula is complicated, but its basic goal is to keep spending for each Medicare enrollee from growing faster than the per capita increase in the GDP. Growth of the GDP was included in the formula under the theory that it is not fiscally sustainable for Medicare physician spending to grow faster than growth of the national economy.

**HOPE NOT REALIZED:** The expectation that this payment system would control spending has not been realized. Despite the prospect of a collective penalty for excess spending growth, individual physicians have no incentive to limit the number of services they furnish. During the first few years under the 1997 rules, physician spending stayed within the targets, and physicians were rewarded with price increases greater than inflation. But for 2002 the updated formula required physician fees to be reduced by almost 5 percent. Congress allowed the reduction to take effect. But when the formula dictated an additional reduction for 2003, Congress overrode the Balanced Budget Act rules and approved a small physician fee increase instead.

That action set a precedent that has continued to this day. In each year since 2003, despite the statutory formula that would have led to a fee cut, Congress has instead either granted an increase or frozen the rates and prevented a decrease. Despite repeated congressional intervention to prevent rate cuts, the formulas that dictate these cuts have not been revisited. Each time Congress has increased fees, it has specified that the updates for later years should be computed as if it had not acted to increase those fees. What’s more, Congress has never modified the SGR targets themselves.

Until lately, the number of services that physicians provided grew steadily, and the services were increasingly costly and complicated. That means that each year there has been a widening gap between actual spending and the targeted spending amount. 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 each time to forestall the cuts, and even to grant physicians small Medicare fee increases.

**FEDERAL DEFICIT CHALLENGE:** Why has Congress consistently acted in this fashion, overriding automatic cuts—but on a short-term basis—14 times so far? The answer is that a longer-range fix could greatly increase the

projected federal deficit. Congress relies on the CBO to measure the impact of proposed legislation. The CBO establishes a baseline, or projections of future spending and revenues, that assumes all current laws will be enforced. The baseline includes all of the physician cuts scheduled to take effect in future years, which would produce substantial savings for Medicare.

Any legislation that overrides future cuts is scored by the CBO as increasing the deficit, relative to the current baseline. However, recent changes that have lowered the estimate of the costs of overriding future cuts now makes a permanent legislative doc fix more likely.

The CBO in February 2013 estimated that eliminating the SGR targets and freezing Medicare physician fees at the current level for 10 years would cost about \$138 billion between fiscal years 2014 and 2023. This was a sharp reduction from the CBO’s most recent estimate of \$245 billion over 10 years. CBO explained that the change was primarily because actual physician payments for the past three years have been less than projected and lower than the spending targets inherent in the SGR.

Many lawmakers might prefer a permanent solution so that they do not have to keep revisiting the issue. However, given the current focus on deficit reduction, Congress is unlikely to enact a costly long-term fix without either finding some way of paying for it or reforming physician payment in a way that justifies accepting a larger deficit.

## WHAT ARE THE PROPOSALS?

Most current proposals would have Congress set Medicare physician payment rates in advance for some fixed number of years. This approach would reduce uncertainty for physicians and make the federal budgetary process clearer and more predictable. In theory, a multiyear payment mechanism would allow time to develop and build approval for more fundamental reforms in the way physicians are paid. The following section reviews some recent proposed fixes (Exhibit 1).

**MEDPAC:** The Medicare Payment Advisory Commission (MedPAC), an independent congressional agency, recently proposed a fix with a price tag of about \$200 billion over 10 years. The MedPAC plan would repeal the SGR provision and set payment rates for the next

# \$138 billion

## Cost to repeal SGR

Eliminating the SGR and freezing physician payment rates would cost \$138 billion between 2013 and 2022, according to a revised estimate from the CBO.

10 years. Rates for patient visits to primary care physicians would be frozen at their current level through 2021. Payments for other services by those physicians, and for all services by nonprimary care specialists, would be reduced by 5.9 percent in each of the three years from 2012 to 2014 and then be frozen through 2021.

Primary care would be exempt from the reductions chiefly because of MedPAC's concern about access to these services. MedPAC notes that primary care physicians are far less likely than specialists to accept new Medicare patients. Because primary care visits account for only a small fraction of Medicare physician spending, only 8 percent of services would be exempt from the cuts.

The MedPAC plan would also reduce payments for "overvalued" services. These are services for which the Medicare price is deemed excessive, relative to the difficulty of providing the service or the physician's overhead costs. For example, automation may have reduced the time it takes a physician to read an electrocardiogram, but the current price may not reflect this.

Cutting payments to specialists makes this plan less expensive than an across-the-board freeze: about \$200 billion over 10 years. The MedPAC proposal includes a list of possible Medicare savings to offset this cost, although MedPAC is not formally recommending any specific item. Among the suggested offsets are requiring drug manufacturers to give rebates to Medicare Part D plans for drugs furnished to low-income beneficiaries, making sharp

cuts in payments to skilled nursing facilities and clinical labs, and imposing an excise tax on Medicare supplemental (Medigap) plans that provide "first-dollar" coverage of Medicare's cost sharing. (See the [Health Policy Brief](#) published September 21, 2011, for more information on Medigap plans.)

Not surprisingly, each of these changes is being strongly opposed by the providers or other groups affected. Specialty groups oppose the rate reductions, and many primary care physicians reject a 10-year freeze. The American Medical Association notes that Medicare fees have risen by less than 5 percent since 2001, although practice costs have grown by nearly 25 percent.

On the other hand, because physicians have been furnishing more services, their Medicare revenues have grown faster than the payment rates. This would continue to be true under the MedPAC proposal. And despite physicians' concerns about Medicare failing to keep pace with practice costs, Medicare's payment rates for physician services are well above those paid in other developed nations. (See the September 2011 *Health Affairs* [article](#) by Miriam J. Laugesen and Sherry A. Glied listed in the Resources section below.)

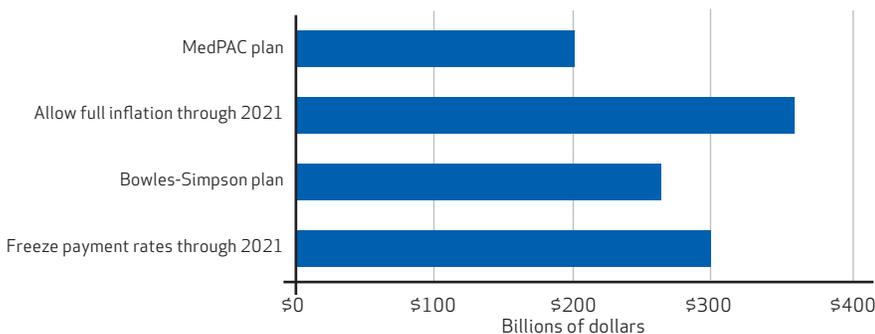
**BOWLES-SIMPSON:** The National Commission on Fiscal Responsibility and Reform, known as the Bowles-Simpson Commission, included a physician payment reform plan among its broader recommendations on balancing the budget. The commission's plan, released in December 2010, would freeze physician payment rates through 2013, reduce rates by 1 percent in 2014, and then reinstate the SGR system in 2015 using 2014 spending as the base year. In effect, past overspending would be forgiven, offering physicians a new chance to restrain spending but threatening them with future penalties for failing to do so. The estimated 10-year cost of this approach is \$261.7 billion, according to the CBO.

**OBAMA ADMINISTRATION:** The White House's fiscal year 2013 budget proposal, released in February 2012, offers a "best estimate" of the cost "to achieve permanent, fiscally responsible reform" but provides no details on what specific measures are intended. Its 10-year projected cost of the doc fix for fiscal years 2013–22 is \$429 billion.

**LONGER-RANGE PAYMENT REFORMS:** Many observers argue that Medicare needs to move beyond the traditional method of paying phy-

## EXHIBIT 1

### Cost of Selected Doc Fix Options, 2012–21



**SOURCES** Congressional Budget Office; Medicare Payment Advisory Commission. **NOTES** MedPAC plan freezes primary care rates at current levels for 10 years and cuts rates for other care by 5.9 percent annually for each of three years, then freezes them for 7 years. The Bowles-Simpson plan freezes rates through 2013, reduces rates by 1 percent in 2014, and reinstates SGR in 2015 using 2014 as the base year.

sicians for each service that they provide to each patient. This fee-for-service approach may encourage the fragmentation of care and the delivery of unnecessary services. There are numerous proposals for payment and delivery system changes that would promote integrated care delivery and encourage cost-effective medical treatment, and many are already under way. However, it will take time for these to be adopted widely.

During 2012 lawmakers in the House and Senate held a number of hearings to explore possible alternatives to the SGR. Physician groups expressed support for legislation that would keep payment rates level or increase them slightly for three or more years, during which time Medicare would continue experimenting with payment reform initiatives, such as pay-for-performance, in which payments are tied to quality and other outcomes measures, or bundling, in which a single payment is made to one entity for a combination of services made by several providers.

One such bill, introduced last year by Rep. Allyson Y. Schwartz (D-PA) and Rep. Joe Heck (R-NV), would scrap the SGR and set up a five-year transition period in which to test new payment models. No hearings on the bill (HR 5707) were held, however. The lawmakers re-introduced a similar bill in February 2013 (HR 574).

**LATEST ACTION:** Unable to agree on any of these alternatives, Congress has up until now

intervened repeatedly with short-term changes to avoid draconian cuts, as noted above. The most recent extension, enacted by Congress on January 1, 2013, and signed into law by President Obama the following day, will keep Medicare physician fees level through the end of 2013. The cost of doing so is to be offset by a variety of Medicare and Medicaid payment cuts to hospitals, including reducing payments for inpatient care, extending the current reduction in rates for uncompensated care, reducing payments and modifying payment rates for blood dialysis services and end-stage renal disease treatments, and reducing payments to Medicare Advantage plans.

### WHAT'S NEXT?

In January 2013, House lawmakers put forward a proposal similar to MedPAC's to repeal the SGR, and more such legislative proposals are likely to be forthcoming in the wake of the CBO's reduced estimates of a permanent doc fix. Any changes may now become part of a broader deal between Congress and the White House to forestall major federal budget cuts, or "sequestration," necessitated by the Budget Control Act of 2011 that will take effect in March 2013 unless Congress acts.

If there is such a deal on Medicare physician payments, it could put an end to a long decade in which federal policy makers regularly delayed scheduled Medicare physician fee cuts and found money to pay for it, one year at a time. ■

#### About Health Policy Briefs

Written by  
**Mark Merlis**  
Health Policy Consultant

Editorial review by  
**Robert A. Berenson**  
Institute Fellow  
Urban Institute

**Paul B. Ginsburg**  
President  
Center for Studying Health  
System Change

**Ted Agres**  
Senior Editor for Special Content  
*Health Affairs*

**Rob Lott**  
Deputy Editor  
*Health Affairs*

**Susan Dentzer**  
Editor-in-Chief  
*Health Affairs*

Health Policy Briefs are produced under a partnership of *Health Affairs* and the Robert Wood Johnson Foundation.

Cite as:  
"Health Policy Brief: Medicare Payments to Physicians." *Health Affairs*, Updated February 13, 2013.

Sign up for free policy briefs at:  
[www.healthaffairs.org/healthpolicybriefs](http://www.healthaffairs.org/healthpolicybriefs)

### RESOURCES

Congressional Budget Office, "[An Update to the Budget and Economic Outlook: Fiscal Years 2012 to 2022](#)," August 2012.

Congressional Budget Office, "[Estimate of the Budgetary Effects of HR 8, the American Taxpayer Relief Act of 2012, as passed by the Senate on January 1, 2013](#)," January 1, 2013.

Congressional Budget Office, "[The Budget and Economic Outlook: Fiscal Years 2013 to 2023](#)," February 2013.

Ginsburg, Paul B., "[Fee-for-Service Will Remain a Feature of Major Payment Reforms, Requiring More Changes in Medicare Physician Payment](#)," *Health Affairs* 31, no. 9 (2012): 1977–83.

Laugesen, Miriam J., and Sherry A. Glied, "[Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services Compared to Other Countries](#)," *Health Affairs* 30, no. 9 (2011): 1647–56.

Medicare Payment Advisory Commission, "[Moving Forward from the Sustainable Growth Rate \(SGR\) System](#)," letter from Glenn M. Hackbarth to chairmen and ranking members of congressional committees, October 14, 2011.

National Commission on Fiscal Responsibility and Reform, "[The Moment of Truth](#)," December 2010.

Office of Management and Budget, "[Living within Our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction](#)," September 2011.