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Health Policy Brief

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Medicare Payments to Physicians. Congress faces another deadline before automatic cuts will kick in—and once again may consider a major overhaul.

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. However, Congress has consistently postponed those cuts and instead raised Medicare physician fees slightly or held them constant.

Unless Congress acts again soon, payment rates for physician services will be reduced by 27.4 percent starting January 1, 2012, according to a new administration calculation.

Congress could simply pass another short-term “doc fix,” as it did most recently in December 2010. But there is growing agreement among lawmakers and policy makers that it would be preferable to find a multiyear plan to stabilize payment rates coupled with a general redesign of the physician payment system.

The challenge is that the Congressional Budget Office has estimated that such a doc fix would increase the federal deficit by about \$300 billion or more from 2012 to 2021. Many analysts suggest that the Joint Select Committee on Deficit Reduction—the so-called Super Committee that is charged with identifying \$1.5 trillion in budget cuts over 10 years—should include a permanent payment rate solution, and a way of paying for it, in its recommendations due in November 2011.

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, assures 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 run-

27.4%

Physician payment reduction

Unless Congress intervenes, Medicare payment rates will be reduced by 27.4 percent starting January 1, 2012.

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

ning 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.

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 update 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 it has increased fees, Congress 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—11 times so far? The answer is that a longer-range fix could greatly increase the projected federal deficit. Congress relies on the Congressional Budget Office (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. The CBO estimates that eliminating the SGR targets and freezing Medicare physician fees at the current level would cost \$298 billion between 2012 and 2021. Allowing the rates to rise at the same rate as projected inflation in the costs of running a doctor’s office would increase the deficit by \$358 billion.

Although many lawmakers might prefer a permanent solution so that they do not have to keep revisiting the issue, given the current focus on deficit reduction, Congress is unlikely to enact a costly long-term fix without finding some way of paying for it.

WHAT ARE THE PROPOSALS?

Most current proposals would have Congress set Medicare physician payment rates in advance for some fixed number of years. This 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 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 legislatively

\$298 billion

Cost to repeal SGR

Eliminating the SGR and freezing physician payment rates would cost \$298 billion between 2012 and 2021, according to the CBO.

for the next 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 non-primary care specialists, would be reduced by 5.9 percent in each of the three years 2012–2014 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 EKG, 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, though 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 plans (Medigap) 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, while 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, and 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.)

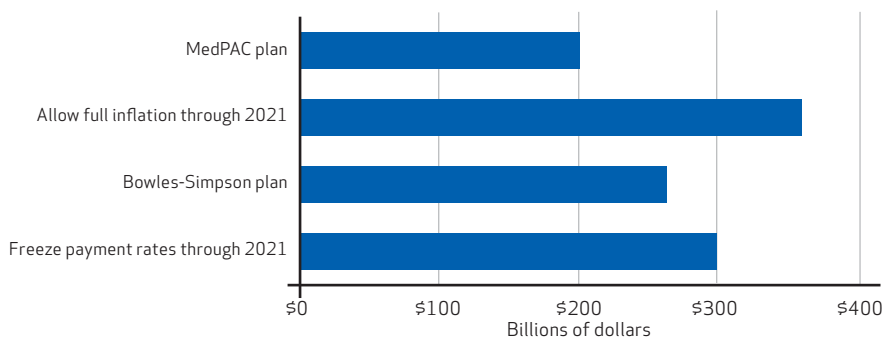
BOWLES-SIMPSON: The National Commission on Fiscal Responsibility and Reform, known as the Bowles-Simpson Commission, included a physician payment reform plan among its broader recommendations on balancing the budget. The commission's plan, released in December 2010, would freeze physician payment rates 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 Congressional Budget Office.

OBAMA ADMINISTRATION: The White House's September 2011 budget proposal uses numbers that assume legislation to fix the SGR policy, but provides no details on what specific measures are intended. The 10-year projected cost of the fix is \$293 billion, which suggests that what is contemplated is a 10-year payment rate freeze.

LONGER-RANGE PAYMENT REFORMS: Many observers argue that Medicare needs to move beyond the traditional method of paying physicians for each service that they provide to

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.

\$200 billion

MedPAC repeal estimate

Eliminating the SGR and freezing then reducing physician payment rates would cost about \$200 billion over 10 years, according to MedPAC.

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.

WHAT'S NEXT?

As this brief is published, Congress is awaiting recommendations from the Joint Select Committee on Deficit Reduction, or Super Committee, which is required to submit a plan that would reduce the federal deficit by at least

\$1.2 trillion from 2012 to 2021. Some analysts suggest that the Super Committee should include long-term physician payment reform in its overall package.

If the committee does not agree on a proposal, or if the proposal does not include Medicare physician payment reform, Congress could pass yet another short-term fix to prevent rate cuts from taking effect in 2012. Under current budget rules, a short-term fix would not require any immediate offsetting savings elsewhere in the budget if Congress passes it before the end of 2011. But because of the way the SGR formula works, the cost of repealing the formula becomes higher every year that Congress puts it off. ■

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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

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