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Executive Summary

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WHY DOCTORS ARE ABANDONING MEDICARE AND WHAT SHOULD BE DONE ABOUT IT

ROBERT E. MOFFIT, PH.D.

Doctors are leaving Medicare. More doctors are not accepting new Medicare patients, and some physicians are withdrawing from Medicare altogether. The reason: Medicare's complex system of administrative pricing is cutting physician reimbursement by 5.4 percent this year while forcing frustrated doctors to comply with an ever growing body of incomprehensible rules and regulations. "For years," writes Robert Pear, veteran reporter on health care policy for *The New York Times*, "doctors have expressed frustration with Medicare, grumbling about reimbursement and complex federal regulations. But the latest reaction appears to be different. Doctors are acting on their concerns, in ways that could reduce access to care for patients who need it."

Remarkably, in spite of the sobering news that doctors are refusing to accept senior citizens enrolled in Medicare, the American Association of Retired Persons (AARP) strongly opposes increased payments to doctors and other providers in Medicare unless Congress first agrees to provide a "meaningful" prescription drug benefit in the Medicare program—a benefit that, under the AARP's own definition, would cost no less than $750 billion over 10 years. This is far in excess of leading Administration and congressional proposals and would guarantee a sharp acceleration of the rapidly rising cost of the financially troubled Medicare program. In making this demand, the AARP is, in effect, holding doctors and other medical professionals hostage even though they, as a class, may not have any specific stake in the cost, design, or structure of the Medicare prescription drug benefit.

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Archaic Central Planning. Medicare is a system of central planning and price regulation in which virtually every aspect of the financing and delivery of medical services to senior citizens is under bureaucratic control. Congress and the Centers for Medicare and Medicaid (CMS), the powerful federal agency that runs Medicare, define which benefits, medical services, and treatments or procedures seniors will (or will not) have available to them in the program. This means that with every benefit change, biomedical breakthrough, or innovation in technology or service delivery, Congress has to change the law or authorize the Medicare bureaucracy to make the appropriate adjustments in changing the benefits or

adding services or procedures. This process is painfully slow and inefficient. Medicare patients must often wait while patients in the private sector may receive much quicker access to new medical services and technologies.

The emerging refusal of physicians to see Medicare patients is an ominous development in the medical community's reaction to the morass of red tape, sluggish and inappropriate payments for services provided, and fears of retaliation for even unintentional noncompliance posed by the current Medicare system. Rather than add to the disincentive to care for Medicare patients, Congress and the Bush Administration should take action to address the systemic problems at their roots with a vision of long-range, substantive reform.

Steps Toward Reform. Seniors' reduced access to care and the deepening demoralization of doctors are rooted in the outdated structure of Medicare itself. Instead of relying on Medicare's systems of central planning and price regulations, Congress should enact structural changes that would enhance patient choice and control over health care decisions and move toward a more rational system. A model for such reform already exists in the popular and successful Federal Employees Health Benefits Program (FEHBP), the patient-centered, consumer-driven system that covers Members of Congress, federal workers and retirees, and their 9 million family members.

To address the problems of Medicare before they reach crisis proportions with the forthcoming retirement of the 77-million-strong baby-boom generation, Congress and the Administration should act quickly to initiate reform in the system. Specifically, they should:

- **Increase Medicare payments to doctors practicing in the Medicare program,** reversing the current 5.4 percent cut in this year's Medicare physician reimbursement.
- **Intensify their review of the regulatory burdens facing doctors and other providers** in the Medicare program and give them timely regulatory relief.
- **Continue to press for comprehensive Medicare reform.**

Congress and the Administration should start to create a new competitive system modeled after the FEHBP. Such a new system, based on patient choice and a competitive market, would enhance the quality of health care for a growing number of senior citizens and improve the working environment for seniors' physicians. In contrast with bureaucratic central planning, the new competitive system would be characterized by rapid innovations in benefits and the efficient delivery of medical services, free of the sluggish bureaucratic process and red tape that hobble benefit setting in the current Medicare program. Doctors, Medicare patients, and the taxpayers who fund this system deserve such reform.

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Doctors are leaving Medicare. More doctors are not accepting new Medicare patients, and some physicians are withdrawing from Medicare altogether. The reason: Medicare's complex system of administrative pricing is cutting physician reimbursement by 5.4 percent this year while forcing frustrated doctors to comply with an ever-growing body of incomprehensible rules and regulations. "For years," according to Robert Pear, veteran reporter on health care policy for *The New York Times*, "doctors have expressed frustration with Medicare, grumbling about reimbursement and complex federal regulations. But the latest reaction appears to be different. Doctors are acting on their concerns, in ways that could reduce access to care for patients who need it."[1]

A FAILED SYSTEM OF CENTRAL PLANNING

According to the *New York Times* report, Medicare reimbursement for doctors in many cases does not even cover the cost of providing care to Medicare patients. Remarkably, in spite of the sobering news that doctors are refusing to accept senior citizens enrolled in Medicare, the American Association of Retired Persons (AARP), the powerful "seniors lobby," has voiced strong opposition to increased payments to doctors and other providers in Medicare unless Congress first agrees to provide a "meaningful" prescription drug benefit in the Medicare program—a benefit that, by the AARP's own definition, would cost no less than $750 billion over 10 years.[2] The high price of this AARP demand is far in excess of leading Administration and congressional proposals and would guarantee a sharp acceleration of the rapidly rising cost of the financially troubled Medicare program.

In reality, as former Senator Robert Kerrey (D–NE), co-chairman of the Concord Coalition, a bipartisan organization dedicated to federal entitle-

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1. Robert Pear, "Doctors Shunning Patients with Medicare," *The New York Times*, March 17, 2002, at *www.nytimes.com*.
2. "AARP Urges Conrad to Consider a $750 Billion Prescription Drug Benefit," *The White House Bulletin*, February 26, 2002, pp. 2–3.

ment reforms, recently reminded the Senate Finance Committee, Medicare is neither fully funded nor a true health insurance program:

> The current un-funded liability for future beneficiaries is $10 trillion *before* a prescription drug benefit is added. Second, it is not true insurance because the insurer is underwriting a risk that is almost certain to be used continually. This is especially true with most of the prescription drug proposals where the usage will be expected and annual.[3]

David M. Walker, Comptroller General of the United States, has similarly observed:

> Frankly, we know that incorporating a prescription drug benefit into the existing Medicare program will add hundreds of billions to program spending over the next 10 years. For this reason I cannot overstate the importance of adopting meaningful financial reforms to ensure that Medicare remains viable for future generations.[4]

In short, the financial costs of a badly designed drug benefit could be enormous for taxpayers and seniors alike.

Pricing Divorced from Reality. Medicare's pricing of medical services is largely divorced from economic reality and overrides the market forces of supply and demand that determine the prices of goods and services in every sector of the American economy. Doctors in Medicare practice are paid through congressionally created formulas and elaborate fee schedules, and their reimbursement is capped through a rigid system of price regulation.

As a result, with regard to a large portion of their services, doctors are today the only class of American professionals who operate under a system of federal price controls. Under current scenarios:

- **Physician pay for Medicare services will be cut by a total of 17 percent between now and 2005.** This is a remarkable reduction in payment for doctors in Medicare, who must also wrestle with restrictive managed care arrangements in a profoundly distorted private health insurance market.
- **Physicians find it increasingly difficult to accept new Medicare patients under the terms and conditions imposed by Congress and the Medicare bureaucracy.** According to the American Academy of Family Physicians, 17 percent of family doctors are refusing to take new Medicare patients. [5]
- **Physicians are drowning in a rapidly growing morass of confusing red tape and bureaucratic paperwork created by Congress.** This regulatory morass undermines efficiency and diminishes the quality of patient care. A recent American Medical Association survey of physicians found that more than one-third of responding doctors spend an hour completing Medicare paperwork for every four hours of patient care.[6] Every precious hour and dollar spent complying with Medicare paperwork means less time and money spent on patient care.
- **Physicians get little help from Medicare and its contractors in interpreting the rules, regulations, and guidelines imposed by the Medicare bureaucracy.** Medicare's rules are so complex and confusing that even Medicare personnel and contractors rarely give physicians and other providers correct answers regarding the system's regulations. According to the U.S. General Accounting Office (GAO), customer

3. Senator Bob Kerrey, Co-Chairman, Concord Coalition, testimony before the Committee on Finance, U.S. Senate, 107th Cong., 2nd Sess., March 7, 2002, p. 3 (author's emphasis).
4. David M. Walker, Comptroller General of the United States, "Medicare: Financial Outlook Poses Challenges for Sustaining Program and Adding Drug Coverage," testimony before the Committee on Finance, U.S. Senate, 107th Cong., 2nd Sess., April 17, 2001, p. 16.
5. Pear, "Doctors Shunning Patients with Medicare."
6. Richard F. Corlin M.D., President-Elect, American Medical Association, "Medicare Reform: Bringing Regulatory Relief to Beneficiaries," statement before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 107th Cong., 1st Sess., March 15, 2001, p. 12.

service representatives from Medicare contractors answered only 15 percent of GAO test questions "completely and accurately."[7]

Medicare's Cumbersome Bureaucracy. Seniors' reduced access to care and the deepening demoralization of doctors are rooted in the outdated structure of Medicare itself: a system of central planning and price regulation in which virtually every aspect of the financing and delivery of medical services to senior citizens is under bureaucratic control. Congress and the Centers for Medicare and Medicaid (CMS), the powerful federal agency that runs the Medicare program,[8] define which benefits, medical services, and treatments or procedures seniors will (or will not) have available to them through the program. Every change in benefits, biomedical breakthrough, or innovation in technology or service delivery means that Congress either has to change the law or authorize the Medicare bureaucracy to make the appropriate adjustments in changing the benefits or adding allowable services or procedures.

This process is both painfully slow and inefficient. Medicare patients must often wait for treatment while patients in the private sector may get much quicker access to new medical services and technologies.

Congress and the Medicare bureaucracy (acting pursuant to congressional requirements) use complex formulas to fix the price of each of the more than 7,000 medical services that 650,000 doctors render to senior citizens. But Medicare's administrative pricing is often distorted or based on inappropriate data; it is often too high or too low. When it is too high, taxpayers overpay for medical services; when it is too low, the availability of services for seniors may be reduced. This was the case with home health care and nursing home services, among others, after the rash of reimbursement reductions enacted in the Balanced Budget Act of 1997 (BBA).

OVERDUE REFORM

Today, as *The New York Times* reports, more seniors are faced with a shortage of physicians' services as a result of doctors' growing dissatisfaction with Medicare, including its reimbursement rates and rules. And doctors, whose professional medical organizations once lobbied extensively for administrative pricing schemes, are getting yet another painful lesson in the pitfalls of price regulation. Substantive, systemic reform is long overdue.

Giving Baby Boomers a New System. Instead of relying on Medicare's systems of central planning and price regulations, Congress should enact structural changes that would enhance patient choice and control over health care decisions and move toward a more rational system. A model for such reform currently exists in the popular and successful Federal Employees Health Benefits Program (FEHBP), the patient-centered, consumer-driven system that covers Members of Congress, federal workers and retirees, and their dependents—altogether 9 million persons.[9]

In the FEHBP,

- Individuals and families select the plans and benefit packages they want from a spectrum of options, all of which include prescription drug coverage.
- Costs are controlled the same way they are controlled in every other sector of the economy—through consumer choice and market competition.
- Federal workers and retirees have access to solid comparative information on the various plans, which is provided by the government and private-sector sources, including federal employee organizations and consumer groups.

7. U.S. General Accounting Office, *Medicare: Communications with Physicians Can Be Improved*, GAO–02–249, February 2002, p. 4.
8. The agency had been known as the Health Care Financing Administration, or HCFA, but the Bush Administration changed its name in 2001, largely because of HCFA's growing unpopularity with the doctors, hospital officials, and other providers who routinely had to deal with it.
9. For a discussion of organizing Medicare along the lines of the Federal Employees Health Benefits Program, see Stuart M. Butler, "The FEHBP as Model for Reforming Medicare," testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, 107th Cong., 2nd Sess., March 20, 2002; see also Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, Vol. 14, No. 4 (Winter 1995), pp. 47–61.

Employees can choose their plans on the basis of desirable combinations of benefits, quality, and price, and can select from plans rated on customer service and satisfaction by reputable organizations.

- More than a dozen competing plans are routinely available to federal employees and retirees in any part of the country. These include private plans that meet standard benefit, fiscal solvency, and consumer protection standards and have been approved by the government.
- Benefit-setting is a continual and flexible process that largely reflects changes in consumer demand.

Both the National Bipartisan Commission on the Future of Medicare and the Bush Administration have proposed this model for the reform of the ailing Medicare program for the next generation of America's retirees.[10]

Immediate Reforms to Meet the Needs of the Elderly. In the meantime, Washington should pursue two immediate changes.

- *First,* Congress should eliminate Medicare's flawed update for payment for physicians' services. A solid basis for making this change is the Medicare Physician Payment Fairness Act of 2001 (H.R. 3351 and S. 1707), sponsored by Representatives Michael Bilirakis (R–FL) and John Dingell (D–MI) and Senators Jim Jeffords (I–VT), Jon Kyl (R–AZ), and John Breaux (D–LA). The legislation would reverse the 5.4 percent Medicare physician payment reduction in calendar year 2000. As a policy matter, Congress should move away from existing arcane administrative formulas and base Medicare payment increases on genuine market conditions.
- *Second,* both Congress and the Administration should intensify their ongoing review of the Medicare regulatory system with a view to eliminating rules, regulations, or guidelines that unnecessarily burden doctors and other medical providers.

WHY DOCTORS ARE FRUSTRATED WITH MEDICARE PAYMENT

The recent 5.4 percent reduction in Medicare physician reimbursement is only the beginning of the cuts facing doctors who have a Medicare practice. According to the Medicare Payment Advisory Commission, under the current legislatively authorized formula for updating physician payment, doctors will face a total reduction in Medicare reimbursement of 17 percent between now and 2005.[11]

Complex and Flawed Payment Formulas. Medicare physician payment is based on an extraordinarily complicated system of administrative pricing. This includes a fee schedule based on the Resource Based Relative Value Scale (RBRVS), under which the value of a medical service is determined according to a social science measurement of the time, energy, and effort involved and the scale of the procedure, as well as malpractice costs and other resource expenses related to the provision of a medical service. According to a formula, these statistical measurements are computed to determine the "objective value" of a medical service, and that "value" is converted into a dollar amount for payment to physicians delivering that service.[12]

Other components of the Medicare physician payment system include a cap on allowable physician charges and a formula to update and limit the overall level of Medicare spending on physicians' services. The method that is currently used to update and control Medicare physician spending is also the immediate source of Medicare physician payment reductions and recent physician dissatisfaction.

10. For a discussion of how to move a Medicare reform agenda, see Robert E. Moffit, "Improving and Preserving Medicare for Tomorrow's Seniors," in Stuart M. Butler and Kim R. Holmes, eds., *Priorities for the President*, A Mandate for Leadership Project (Washington, D.C.: The Heritage Foundation, 2001), pp. 31–52.
11. Glenn M. Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission, "MEDPAC Recommendations on Physician Payment Policy," statement before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 28, 2002, p. 1.
12. For a discussion of the Medicare physician fee schedule, its rationale, and its implementation, see Robert E. Moffit, "Back to the Future: Medicare's Resurrection of the Labor Theory of Value," *Regulation*, Fall 1992, pp. 54–63.

Under the BBA, Congress created a new formula to increase Medicare payment for doctors. That annual payment increase is supposed to be equal to increases in the costs of goods and services used in providing medical services, but the costs for doctors practicing medicine have, of course, been rising. Indeed, medical practice costs—including medical malpractice costs—have been outpacing Medicare physician payment rates in recent years.

However, these cost increases alone do not determine annual Medicare payment updates for physicians. Rather, any increase in Medicare physician payment must also equal a set target for overall increases in Medicare Part B spending.

That spending target is set by a congressionally created formula called the Sustainable Growth Rate (SGR). Through this formula, the Medicare bureaucracy computes an annual target for Medicare spending on physicians' services by calculating, among other things, the changes in gross domestic product (GDP), enrollment in Medicare, and pricing related to the provision of physicians' services. For example, an increase in the GDP would normally result in an increase in the target level of Medicare spending, as would increases in such factors as medical practice costs or Medicare enrollment, and physicians would therefore receive an increase in Medicare payments. The problem with this calculation is that the growth of GDP, or the state of the general economy, may have nothing to do with physicians' activity or the costs incurred in providing a medical service to Medicare patients.

Because Medicare payment is governed by Medicare's SGR formula, the recent recession has altered the GDP component of the equation, pushing the Medicare spending target downward. Worse, the Medicare spending target to be calculated under the SGR formula has been further compromised by the Medicare bureaucracy's use of outdated and inappropriate data related to physicians' services, which is incorporated in calculation of Medicare's payment to doctors. As the Medicare Payment Advisory Commission recently told Congress, the problems created by an inherently flawed formula have been aggravated by the Medicare bureaucracy's use of old and inappropriate data.[13]

This most recent decrease in Medicare physician payment will surely have an impact on physicians beyond the bureaucratic confines of Medicare. Ominously, many private-sector insurance plans and state Medicaid agencies follow Medicare payment schedules. Because the SGR formula, as well as the other Medicare payment formulas, are created by law, Medicare officials cannot change them either easily or quickly to cope with rapidly changing economic conditions. Thus, unless Congress takes remedial action quickly, doctors face not only projected Medicare payment cuts, but also reductions in reimbursement from the private and public agents that slavishly follow Medicare's flawed systems of administrative pricing.

Unintended Consequences. Current policy reflects a debunked but persistent congressional faith in the effectiveness of central economic planning in Medicare. When Members of Congress changed the way the Medicare bureaucracy would update physician payment in 1997, they erroneously thought that this would be an improvement over previous formulas for administering Medicare pricing for physicians' services and for controlling Medicare's costs.[14] The payment updates were based on an assumption of a direct relationship between the state of the general economy (as measured in GDP) and the costs of medical services provided by physicians.

In fact, the validity of this relationship has not been established, and Medicare price updates based on that formula are disconnected from the actual costs to physicians in providing services. As Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission, recently told Congress, this elaborate process to fix prices "accurately" for indi-

13. Hackbarth, "MEDPAC Recommendations on Physician Payment Policy," p. 4.

14. The SGR formula replaced a mechanism called the Volume Performance Standards (VPS). The object of the previous policy was similar: to control physician payment each year by linking Medicare payment to an expenditure target. In this case, Medicare payment increases were linked to the overall volume of medical services provided by physicians the previous year. If the volume targets were exceeded, the physicians would receive a reduced level of reimbursement. Precisely how general volume performance was to be related to incentives for individual physicians to limit the volume of their own provision of medical services was never adequately explained by the congressional authors of this policy. The SGR formula is a variation on the same theme.

vidual services is logically incompatible with the imposition of a general expenditure target for Medicare Part B spending:

> The SGR system causes payments to diverge from costs because although the system accounts for inflation in input prices, productivity growth and other factors affecting costs, it overrides these factors to achieve an expenditure target based on growth in real domestic product (GDP) per capita. If actual spending for physician services differs from the expenditure target, updates under the SGR system will diverge from costs. When this occurs, payments will be either too low, potentially jeopardizing beneficiaries' access to care, or too high, making spending higher than necessary.[15]

Indeed, the SGR formula rests on false assumptions and creates incentives for physicians that are fundamentally at odds with the congressional goal of restrained Part B spending. As Hackbarth explains:

> An expenditure target approach, such as the SGR, assumes that increasing updates if overall volume is controlled, and decreasing updates if overall volume is not controlled, provides physicians a collective incentive to control the volume of services. However, this assumption is incorrect because people do not respond to collective incentives but to individual incentives. An individual physician reducing the volume does not realize a proportional increase in payments. Instead, the increase in payments is distributed among all physicians providing services to Medicare beneficiaries. If anything, in the short run, an individual physician has an incentive to increase volume under such a system and the sum of those individual incentives will result in an increase in volume overall. In fact, CMS makes exactly that assumption when it estimates the so-called behavioral response of physicians to lower payments—which is an increase in volume of services provided.[16]

Loss of Confidence. While Members of Congress and many of Washington's health policy analysts may entertain a strong belief in the efficiency or effectiveness of Medicare's system of administrative pricing, most health care professionals, including doctors and hospital administrators, generally do not. In a 1999 survey of physicians conducted by the Medicare Payment Advisory Commission, a full 45 percent of the respondents said that their Medicare reimbursement was a "very serious problem," though the negatives about Medicare reimbursement were not as strong as the negatives about Medicaid or HMO reimbursement.[17]

In a May 2000 survey conducted by Yankelovich Partners, a prominent survey research firm based in Claremont, California, 82 percent of health care professionals stated that they did not think Medicare reimbursement schedules were "fair."[18] When asked whether Medicare reimbursement schedules ensure that Medicare patients receive quality care, 71 percent of health care professionals said no.[19]

Similarly, when a system is based on central planning, the quality of information is crucial, but only 24 percent of health care professionals surveyed said that they believe federal policymakers have "accurate information" concerning the "operating margins" of health care providers.[20] Not surprisingly, only 7 percent of health care professionals

15. Hackbarth, "MEDPAC Recommendations on Physician Payment Policy," p. 3.

16. *Ibid.*

17. Medicare Payment Advisory Commission, *Survey of Physicians About the Medicare Program*, a study conducted by the Project Hope Center for Health Affairs, September 1999, p. viii.

18. *Changing Medicare for the Future: A Vanderbilt University Medical Center Leadership Survey*, conducted by Yankelovich Partners, Claremont, California, May 2000, and printed in *Proceedings*, "Medicare Futures, a Conference to Refine the National Debate on Medicare," Vanderbilt University School of Medicine, May 1, 2000, p. 68. Cited hereafter as *Medicare Futures Proceedings*.

19. *Ibid.*

20. *Ibid.*, p. 66.

said that they were "very confident" in the Medicare bureaucracy's statistical information.[21]

The Threat to Medicare Patients. Based on the Medicare Payment Advisory Commission surveys of physicians up to 1999, more than 95 percent of doctors indicated a willingness to accept new Medicare patients.[22] But since 1999, the Commission says, Medicare payments have not kept up with the prices to provide physicians' services, indicating that payments might be too low.[23] According to the recent *New York Times* report, Medicare physician payments are indeed too low.

A congressional refusal to fix Medicare payment would result in serious problems of access to care for seniors citizens. In the words of Chairman Hackbarth:

> Over a longer period, if payments were clearly less than physicians' marginal costs of providing a service, we might see physicians cut back their Medicare practice and concentrate on other patients, devote more time to other professional or leisure activities, or leave practice altogether. Ultimately, we could see fewer applicants to medical school or a shift in residency preferences away from those specialties most heavily dependent on Medicare. The result eventually would be decreased access for Medicare beneficiaries which would be very difficult to reverse.[24]

It should be noted that this particular method of updating Medicare payment is confined to Medicare payment to physicians and other providers under Medicare Part B, the part that pays doctors for treating Medicare patients. It does not apply to Part A, the part that pays hospitals.

WHY DOCTORS ARE FRUSTRATED WITH THE MEDICARE BUREAUCRACY

Physicians and medical service providers not only are confronted with decreases in payments for Medicare services, but also are forced to deal with obstacles within the onerous Medicare bureaucracy.

Reams of Red Tape. Detailed central planning requires meticulous regulation. This is inherent in the system and inescapable. Thus, Medicare is governed by a vast and growing body of red tape, with pages of rules, regulations, guidelines, and related paperwork numbering in the tens of thousands and continually increased by Congress.

In the Balanced Budget Act of 1997, for example, Congress gave the Medicare bureaucracy more than 700 additional specific directives.[25] According to a consensus statement on Medicare reform by health care policy experts, based on a May 2001 conference on Medicare at Vanderbilt University School of Medicine, "Paperwork and compliance costs have forced providers to employ staff dedicated to the process—rather than to providing health care. The increasing complication of paperwork and compliance with regulations, has resulted in less time for providers to spend with patients."[26]

This enormous regulatory regime, with the sea of paperwork it generates, dwarfs that of other federal agencies; it also is necessarily and painfully slow. According to the GAO, in the late 1990s, the period between the Medicare bureaucracy's initial proposal for a rule and the final publication of that rule was, on average, nearly two years.[27]

The Fear Factor. Regulation and other administrative guidelines apply not only to pricing, but also to the provision of medical benefits. Every Medicare benefit, and every change or modification in medical benefits, treatments, or procedures, is accompa-

21. *Ibid.*, p. 67.

22. Hackbarth, "MEDPAC Recommendations on Physician Payment Policy," p. 8.

23. *Ibid.*

24. *Ibid.*, pp. 3, 4.

25. Medicare Payment Advisory Commission, *Report to the Congress: Reducing Medicare Complexity and Regulatory Burden*, December 2001, p. 14.

26. *Medicare Futures Proceedings*, p. 72.

27. William J. Scanlon, Director, Health Care Issues, U.S. General Accounting Office, *Medicare: Successful Reform Requires Meeting Key Management Challenges*, testimony before the Committee on the Budget, U.S. House of Representatives, GAO–01–1006T, July 25, 2001, p. 3.

nied by stipulations that are specified by the Medicare bureaucracy or its contractors. This could include, for example, limitations on the benefit or medical service, including whether the medical service is deemed "necessary and appropriate" for senior citizens and under what conditions it is to be deemed so.

The Medicare bureaucracy oversees the annual processing of roughly 900 million claims. Reimbursement for these claims is tied to physicians' compliance with the multitude of government rules and guidelines. Failure of doctors to comply, or even mistakes in compliance, can lead to government audits and investigations of doctors for fraud and abuse. As an editorial in *The Wall Street Journal* recently noted, "There are genuine cases of Medicare fraud, but often a simple clerical mistake or misrepresentation has tripped up otherwise honest people."[28]

Doctors practicing in Medicare have to be especially careful and must make sure that they are on firm ground when submitting claims or interpreting the Medicare rules. Ironically, as GAO investigators discovered, doctors may not get accurate information from Medicare personnel or contractors:

> Medicare information provided by carriers for physicians is often difficult to interpret and use, out of date, inaccurate, and incomplete. Our analysis of the three main methods that carriers use to communicate information to physicians—printed bulletins, provider assistance call centers, and web sites—revealed problems with all three types of communications.[29]

The Medicare Payment Advisory Commission recently took note of the fact that doctors who are misinformed by the CMS or Medicare contractors could nevertheless be subject to sanctions for acting on that bad advice. In response, the Commission recommended that

> The Medicare program should provide timely, binding written guidance to plans and providers. Plans and providers that rely on such guidance should not be subject to civil or criminal penalties or be required to refund related payments if that guidance is later found to be in error.[30]

Though Medicare fraud and abuse is a real problem, there is no solid evidence that fraudulent behavior on the part of doctors in particular is widespread. Rather, what *is* clearly widespread is physician fear of false charges of Medicare fraud or reputation-ruining government investigations and punitive settlements over disputed claims. As the Medicare Payment Advisory Commission notes, though very few of the nation's 650,000 physicians enrolled in the Medicare program are audited or prosecuted, Medicare today creates an inhospitable atmosphere for practicing medicine:

> [T]he fear of unwarranted fraud accusations is real and influences providers' perceptions of the burden of the program. Many feel they cannot win; the program is so complex they are bound to miss some requirements no matter how hard they try to comply and the penalty for non-compliance is perceived to be harsh.[31]

The steady growth of Medicare regulation has been accompanied by an increase in Medicare police enforcement. With rapid advances in biomedical research and medical technology, and with its application in the form of new treatments or medical procedures, the Medicare bureaucracy will be faced with the ever-increasing tasks of approving, coding, and paying for these medical services, as well as writing rules and guidelines for their reimbursement. To protect the public against waste, fraud, and abuse, audits, investigations, and routine monitoring will also continue. It is hard to imagine how, under the current Medicare structure, it could be otherwise.

Thus, without structural reform of the program, Medicare's regulatory complexity can only worsen for doctors and medical specialists. For patients,

28. Editorial, "The Medicare Police," *The Wall Street Journal*, April 1, 2002.

29. U.S. General Accounting Office, *Medicare: Communications with Physicians Can Be Improved*, p. 7.

30. Medicare Payment Advisory Commission, *Report to the Congress: Reducing Medicare Complexity and Regulatory Burden*, p. 22.

31. *Ibid.*, p. 10.

the consequences will be worse: a denial of access to high-quality health care.

Partisan Budget Politics. Individual physicians are often at the mercy of distant political forces they cannot control. A daily routine that includes patient care, coping with medical emergencies, counseling friends and relatives of patients, making hospital rounds, and keeping office hours often does not allow doctors to take time out from their hectic professional schedules to keep up with the latest Medicare changes being deliberated within the confines of the House Ways and Means Committee or the Senate Finance Committee—let alone the latest issuance of the Medicare bureaucracy in the *Federal Register*.

Moreover, doctors cannot escape the fallout from the bitter partisan politics of the federal budget process. For example, while both the Bush Administration and congressional Democrats and Republicans alike are committed to establishing prescription drug coverage for Medicare patients, their plans differ in structure and design. Even though physicians, as a class, may not have any specific stake in the cost, design, or structure of a Medicare prescription drug benefit, AARP officials are virtually holding them hostage to achieve their preferred policies. The AARP has declared that it would block "give backs" in Medicare payments to doctors and other providers unless Congress first agrees to add a $750 billion drug benefit to the existing Medicare program. In a letter to Senate Budget Committee Chairman Kent Conrad (D–ND), William Novelli, chief executive officer of the AARP, declared:

> We believe that it would be irresponsible to use Medicare (or Social Security) surplus dollars to increase provider payments without first ensuring that older Americans get the prescription drugs coverage they need and deserve. Our members would not understand why Congress could find money to help providers but not to meet their increasing drug needs. We therefore would strongly oppose funding for a "give-backs" package prior to an agreement on a meaningful Medicare improvement package that includes drug coverage.[32]

Without substantial reform of Medicare, doctors and patients alike can expect that in the future, more and more crucial health care decisions—including decisions as to the kind and quality of medical benefits available—will be at the mercy of turbulent Capitol Hill politics.

THE URGENT NEED FOR A SUPERIOR MEDICARE SYSTEM

The emerging refusal of physicians to see Medicare patients is an ominous development. It is also yet another compelling reason why the Bush Administration and Congress should quickly set in motion authentic reform for Medicare by taking the following steps:

1. **Increase Medicare payments to doctors practicing in the Medicare program.** One way to accomplish this is to build on the Medicare Physician Payment Fairness Act of 2001 (H.R. 3351 and S. 1707), sponsored by Representatives Michael Bilirakis (R–FL) and John Dingell (D–MI) and Senators Jim Jeffords (R–VT), Jon Kyl (R–AZ), and John Breaux (D–LA). This legislation would reverse the 5.4 percent cut in Medicare physician reimbursement for calendar year 2002. Meanwhile, Congress and the Administration should muster the courage to ignore pressure tactics from politically powerful organizations such as the AARP and pursue reform in reimbursements to Medicare doctors as well as comprehensive, market-based reform of the Medicare program.
2. **Intensify the review of the regulatory burdens facing doctors and other providers in the Medicare program and give them timely regulatory relief.** A number of congressional committees—specifically, the House Budget Committee, House Commerce Committee, House Ways and Means Subcommittee on Health, and Senate Aging Committee—have performed a valuable public service during the past two years by highlighting the nature and scope of the regulatory burdens imposed on doctors and hospitals. Likewise, the Bush Administration has taken the initiative in addressing Medicare's regulatory and paper-

32. "AARP Urges Conrad to Consider a $750 Billion Prescription Drug Benefit," p. 3.

work burdens. The U.S. Department of Health and Human Services (HHS) has created an Advisory Committee on Regulatory Reform, which is conducting field hearings on the impact of Medicare rules on doctors, hospitals, and other providers and is expected to make a report in the fall of 2002. Nonetheless, Congress and the Administration should not miss any opportunity to ease the burdens on doctors and other providers in the Medicare program.

3. **Continue to press for comprehensive Medicare reform.** Washington policymakers should not simply treat the symptoms of Medicare's regulatory problem; they should attack the problem at its roots. An old system based on centralized planning and detailed regulation is incompatible with a 21st century model of health-care financing and delivery that is open, flexible, pluralistic, and finely attuned to consumer choice. The Bush Administration and Congress should undertake the challenging and difficult task of systemic reform in the Medicare program.

   The National Bipartisan Commission on the Future of Medicare, the Bush Administration, and leading Members of Congress in both the House and Senate have outlined the basis for reform: a model based on the positive experience of the Federal Employees Health Benefit Program, the patient-centered system that enables Members of Congress and federal workers and their families to select for themselves the kinds of plans and benefits they want at the prices they wish to pay.

   Unlike Medicare, the FEHBP does not force doctors to labor under a centralized government system of administrative pricing and price controls. Rather, they can choose to participate in different plan options with different reimbursement options. Unlike the Medicare bureaucracy, the Office of Personnel Management (OPM), the agency that runs the FEHBP, does not impose a comprehensive standardized benefit package and does not specify in detail what medical treatments or procedures enrollees will or will not get, conditioning reimbursement on compliance with increasingly complex rules and regulations. Rather, private plans in the FEHBP are allowed to offer competitive packages of benefits, medical treatments, and procedures, subject to negotiation and the satisfaction of patient demand. And unlike Medicare today, all health plans in the FEHBP offer prescription drug coverage, with the plans paying between 80 percent and 90 percent of the cost of coverage.

   With patients having the right to choose and health plans competing in a market to deliver quality medical services, the dynamics of the system are entirely different from Medicare's. With choice and competition doing the heavy lifting, it is not surprising that the FEHBP's regulatory regime is slight in comparison with Medicare's.

CONCLUSION

The recently reported decline in the number of doctors accepting new Medicare patients and the growing demoralization of the medical profession are largely attributable to Medicare's cumbersome and outdated system of central planning and administered pricing. Even now, Medicare is having trouble serving the roughly 40 million senior and disabled citizens who depend on the care it provides. If Washington policymakers fail to make the necessary structural changes in the system today, they can expect that prospects will only worsen for the 77-million-strong baby-boom generation that will begin retiring in just nine years.

The rising cost of Medicare's bureaucracy and red tape, and its negative impact on doctors and patients alike, should provide Congress and the Administration with an incentive both to deal with those problems that can be fixed immediately and to initiate a comprehensive program of systemic reform. As immediate steps, Congress should reverse the 5.4 percent Medicare pay cut, eliminate the SGR formula, and update physician service payments on the basis of market conditions. Both Congress and the Administration should intensify their regulatory review and eliminate costly and complex rules and regulations that unnecessarily burden doctors practicing in Medicare.

It is not enough to treat the symptoms of the Medicare problem. To meet the emerging needs of the baby-boom generation, Congress and the Administration should take steps soon to create a new competitive system modeled after the FEHBP, the successful program that covers themselves and their families. Such a new system, based on patient choice and a competitive market, would enhance the quality of health care for a growing number of senior citizens and improve the working environment for seniors' physicians.

In contrast with bureaucratic central planning, the new competitive system would be characterized by rapid innovations in benefits and the efficient delivery of medical services, free of the sluggish bureaucratic process and red tape that hobble benefit setting in the current Medicare program. Doctors, Medicare patients, and the taxpayers who pick up the tab deserve a superior system.

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