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# A Predictable Mess: Medicare's Physician Payment System Offers Lessons Against Drug Price Negotiation

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When Medicare was enacted in 1965, Congress statutorily prohibited government interference in the practice of medicine. That prohibition has largely been ignored in practice, and today Medicare doctors endure a complex and cumbersome administrative pricing system for the more than 7,000 physician services that beneficiaries receive.[1] This system fails to reduce costs, limits access to medical care, threatens patient choice, and ignores value. Imposing this same model on the Medicare prescription drug benefit by instituting government price "negotiation" would lead to similar consequences.

In the Medicare Modernization Act of 2003, Congress stipulated that government would not interfere with private sector price negotiations for drugs. Recently, the House of Representatives passed legislation to overturn this ban on government interference, and the Senate is considering similar action.

The House's action is puzzling in view of the drug cost reductions already achieved through private negotiation. Secretary Michael Leavitt of the Department of Health and Human Services (HHS) has voiced serious doubts that his department could negotiate better prices than providers and consumers in the competitive marketplace.[2] Secretary Leavitt's doubts are well founded. Medicare beneficiaries with common chronic conditions (whose prescription drug use is highest) enrolled in Medicare prescription drug plans (PDPs) are seeing significant savings in their prescription drug costs.[3] Furthermore, the nonpartisan Congressional Budget Office (CBO) doubts that federal price negotiation would lead to reduced spending or significant savings.[4]

Under the House bill, the Secretary of HHS does not have the power to really "negotiate" drug prices in the normal sense because his use of drug formularies would be prohibited. That means that the only viable way for the government to reduce drug spending would be similar to how it controls physician spending today: fix and administer prices.[5] Given the troubled history of administrative pricing in the Medicare physician payment system, it is stunning that Members of Congress would want to import this process into the Medicare drug benefit program.

**The Lessons of Medicare Physician Payment.** With the Balanced Budget Act of 1997, Congress introduced the sustainable growth rate mechanism (SGR) that currently governs payment to physicians in the Medicare program. SGR ties annual Medicare physician payment updates to changes in the national gross domestic product (GDP). Administrative pricing has proven to be a flawed system. Specifically, it:

- **Fails to reduce costs**. Setting prices has historically resulted in predictable changes in behavior; in trying to make up losses for artificially

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low prices per procedure, physicians increased the volume and intensity of services. So costs continued to rise. From 1997 (which is when the SGR method started measuring expenditures) through 2005, per-beneficiary spending on services paid for under the physician fee schedule grew by 65 percent, or about 6.5 percent per year.[6]

- **Limits access.** Although Congress voted to prevent a 5.1 percent payment cut to physicians in 2007, the administrative pricing system remains in effect. The cumulative cuts under the SGR system are predicted to reach 34 percent by the year 2015. Reductions of that magnitude will likely lead to a significant cutback in the availability of physicians' services. Fully 82 percent of physicians say they will need to make significant changes to their practices that will affect access to care if these cuts go into effect.[7] In any case, whether the commodity is a service provided by a physician or a drug developed by a pharmaceutical company, paying less will never increase the quantity on offer.
- **Threatens choice.** Decisions that affect health care spending occur at the individual patient-physician level. A centralized planning system, with blunt bureaucratic instruments like the SGR linked to arbitrary national targets that have little or nothing to do with the market for physicians' services, severely threatens choice at the individual level. If physicians stop seeing Medicare patients, patient choice will be severely compromised.
- **Ignores value.** Administrative pricing systems pursue a simple-minded objective: cut costs. Costs, however, are only half of the value equation. In Medicare physician payment, the SGR mechanism has no link to the quality of the services provided and contains no incentives for physicians to provide, or for patients to demand, better quality of care.

**Administrative Pricing in the Drug Benefit Program.** If the government administers drug pricing, problems analogous to the mess in the Medicare physician payment system will arise, including:

- **Failure to reduce costs.** Administrative pricing for drugs in the Medicare program would involve blocking access to certain drugs or reducing the availability of certain drugs. This would show savings to the bottom line of the Medicare program but would also likely increase out-of-pocket costs for beneficiaries and lead to predictable changes in behavior. Physicians may change treatment behavior, prescribing less expensive but less effective medications to address patients' cost concerns. A less effective drug may necessitate prescribing additional medications or require additional visits to the doctor or unnecessary

1. For a full discussion of Medicare physician payment, see John S. O'Shea, "The Urgent Need to Fix Medicare's Physician Payment System" Heritage Foundation *Backgrounder* No. 1986, December 5, 2006, at *www.heritage.org/Research/HealthCare/bg1986.cfm*.
2. Mike Leavitt, "Medicare and the Market: Government shouldn't be negotiating prescription prices," *The Washington Post,* January 11, 2007, p. A-25.
3. Centers for Medicare and Medicaid Services, "Medicare Drug Coverage Provides Significant Price Discounts and Savings-Updated Full Report," September 20, 2006, at *www.cms.hhs.gov/apps/media/press/release.asp?Counter=1967*.
4. Letter from Donald B. Marron, Acting Director of the Congressional Budget Office, to Rep. John Dingell (D-MI), Chairman of the Committee on Energy and Commerce, U.S. House of Representatives, January 10, 2007, p.1.
5. Donald B. Marron, "Medicare's Physician Payment Rates and the Sustainable Growth Rate," Congressional Budget Office Testimony before the Subcommittee on Health Committee on Energy and Commerce, U.S. House of Representatives, July 25, 2006, p. 3, at *www.cbo.gov/ftpdocs/74xx/doc7425/07-25-SGR.pdf*.
6. For a discussion of the limits of drug negotiations, see Greg D'Angelo and Robert E. Moffit, Ph.D., "H.R. 4: A Confusing and Contradictory Prescription for Medicare Drugs," Heritage Foundation *WebMemo* No. 1306, January 12, 2007, at *www.heritage.org/Research/HealthCare/wm1306.cfm*.
7. American Medical Association, "2006 AMA Member Connect Physician Survey: Physicians' Reactions to the Projected Medicare Payment Cuts," at *www.ama-assn.org/ama1/x-ama/upload/mm/468/medicarepaymentmc.pdf* (November 20, 2006).

hospitalization, which would increase overall Medicare spending.

- **Limiting access.** The ostensible point of enacting the Medicare drug benefit was to increase access to needed prescription drugs for America's seniors. But if the government sets drug prices, those drugs that the government deems too expensive will not be available to beneficiaries who can not pay out of pocket.
- **Limiting choice.** Currently, the Medicare drug benefit program makes use of prescription drug plans that negotiate prices in the marketplace. Unlike Medicare, these plans can truly negotiate, since they are willing to use the tool of refusing to purchase drugs they feel are overpriced for the market they are serving. Today, if Medicare beneficiaries are dissatisfied with the outcome of a particular plan's price negotiations and the range of drugs available, they can simply switch plans. Currently, there are 1,875 stand-alone plans nationwide.[8] With administrative pricing, that choice will largely disappear. The only alternative for seniors would be to pay out of pocket for uncovered drugs or settle for less effective substitute drugs or other treatment.
- **Ignoring value.** Just like the Medicare physician payment system, administrative pricing for drugs would pursue the goal of short-term cost reduction and ignore the longer-term implications of inferior treatment of certain illnesses with less expensive, less effective medications. These longer-term effects are important not only in terms of health care spending, but also in terms of quality health care for America's seniors.

**Conclusion.** Private negotiation and competition in the Medicare drug program has thus far achieved significant savings for America's seniors. Recently enacted House legislation (H.R. 4), however, would require the Secretary of HHS to "negotiate" drug prices for Part D Medicare beneficiaries, overturning the prohibition on government interference in private negotiation. Since the Secretary could not use a formulary, under the House bill, the conventional tool for negotiation would be denied to him, and thus a system of administrative pricing or price controls would be his only option left to achieve further cost reduction.

As senators weigh the merits of such an approach, they should keep in mind that the Medicare physician payment system—a combination of administrative pricing and price controls—is a mess. It should serve as a warning. Administrative pricing for more than 7,000 physicians' services has failed to reduce Medicare spending, lacks the proper incentives to promote value, and threatens personal choice and access to quality health care for America's seniors. The maladies of this physician payment system should not be allowed to infect seniors' access to drugs.

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8. Jack Hoadley, Elizabeth Hargrave, Katie Merrill, Juliette Cubanski, and Tricia Neuman, "Benefit Design and Formularies of Medicare Drug Plans: A Comparison of 2006 and 2007 Offerings: A First Look" The Henry J. Kaiser Family Foundation, November 2006, at *www.kff.org/medicare/upload/7589.pdf*.