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Medicare Reform: Cleaning Up the Physician Payment Mess

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Congress is about to undergo its annual, eleventh-hour ritual of reconsidering its own statutory requirement to cut Medicare physician payments. Under current law, deep cuts are scheduled to take effect on January 1, 2008. This ritual is the result of Congress's refusal to reform the physician payment system and, more importantly, Medicare itself. For the sake of patients and the Medicare program, Congress should seize this opportunity to move away from administrative pricing toward a new system driven by consumer choice and competition.

The Current Policy. Under current payment formulas, the Centers for Medicare and Medicaid Services (CMS) administers prices for approximately 7,500 physician services. The government attempts to curtail excessive Medicare spending through complex fee schedules and caps on physician charges to Medicare patients. The specific method for updating physician payment formulas each year is itself based on a special formula—the Sustainable Growth Rate (SGR), which is linked to Gross Domestic Product (GDP). Under the current SGR formula, Medicare doctors would see a 10.1 percent reduction in their fees in 2008; cumulative cuts would reach 34 percent by 2015.[1] If not reversed, this process could have a devastating impact on patient access to care, particularly among new Medicare patients.

Meanwhile, U.S. Department of Health and Human Services (HHS) Secretary Michael Leavitt has told Congress that the President's senior advisers would recommend a veto of any bill that, among other things: raises taxes to fund additional federal spending, reduces patient choice in the Medicare Advantage program, undermines the Medicare prescription drug program, or repeals "early warning" provisions that signal excessive reliance on general revenues to finance Medicare.[2]

A Better Policy. Rather than prolonging the problem for yet another year, Congress should start taking serious steps to preserve access to, and improve, the quality of the health care services that all Medicare beneficiaries receive. Serious reform would require replacing the current system of national expenditure targets and administrative pricing with market incentives. Individual providers and patients would then face the same incentives as people in every other sector of the American economy.

Specifically, Congress should do the following:

- **Abandon the flawed SGR methodology.** The current SGR methodology is based on changes in GDP and estimates of the cost of providing 7,500 individual services. Aggregate cost containment incentives do not affect spending at the level of individual patients and providers, and efforts to better define the true costs of delivering physician services have so far been unsuccess-

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ful. SGR should be discontinued and replaced by a new system that provides for normal economic incentives that are relevant to the individual clinical situation.

If Congress decides to establish a new baseline—whether it is the consumer price index (CPI) or the Medicare economic index (MEI)—the annual payment to physicians, accounting for the differences in specialties, should be refined to make updates more rational. For example, specific adjustments could be based on annual market surveys conducted by the Medicare Payment Advisory Commission (MedPAC).

- **Begin transforming the entire Medicare program into a defined-contribution system.** Currently, CMS tries to determine the "right prices" for thousands of medical treatments and procedures, enforcing them with thousands of pages of rules and regulations. Congress should start to move all new retirees to an entirely new system based on defined contributions and powered by the free-market principles of choice, competition, and price transparency. Such a system would drive improvements in quality and allow workers to take their health plan of choice with them into retirement.

  A fixed payment, like that required under the formula that determines government contributions to health plans in the Federal Employees Health Benefit Program (FEHBP), would limit taxpayers' exposure and make Medicare budgeting more manageable and predictable. At the same time, this approach would give beneficiaries more direct control over their health care resources, intensify plan and provider competition, make both patients and providers more cost-conscious, and encourage the demand for price and quality transparency.

- **Preserve choice for current beneficiaries by maintaining the viability of the Medicare Advantage (MA) program.** The President's advisors are right to counsel a veto if Congress disrupts this popular program. Currently, one in five Medicare beneficiaries takes advantage of the choices provided by firms offering MA plans, and enrollment has increased dramatically over the past several years. The Congressional Budget Office predicts that MA enrollment will reach 26 percent of all Medicare enrollments by 2017.[3] Furthermore, enrollment in MA plans continues to grow among the nation's most vulnerable seniors. Fifty-seven percent of MA beneficiaries have incomes between $10,000 and $30,000.[4]

  These plans are popular because they give patients a choice and provide additional benefits beyond the traditional Medicare package, such as lower cost-sharing and reduced premiums for Parts B and D. Reducing payments to MA plans, as some in Congress would like to do, would eliminate any incentive to enroll in the program and would remove the level of choice that currently exists in the Medicare program.

- **Allow genuine competition and consumer choice to drive value in the system.** Concern about rapidly increasing costs and the quality of services in Medicare is understandable. However, government efforts to control spending are flawed, and new variants on these regulatory themes are hardly promising. One such idea is to link physician payment to adherence to process guidelines in medical treatment. However, these guidelines may have little to do with clinical out-

1. For a discussion of the development of the current Medicare physician payment system, see John S. O'Shea, M.D., "The Urgent Need to Reform Medicare's Physician Payment System," Heritage Foundation *Backgrounder* No. *1986*, December 5, 2006, at *www.heritage.org/Research/HealthCare/bg1986.cfm*; for a discussion of the SGR methodology within the Medicare physician payment system, see Robert E. Moffit, Ph.D., "Why Doctors Are Abandoning Medicare and What Should Be Done About It," Heritage Foundation *Backgrounder* No. 1539, April 22, 2002, at *www.heritage.org/library/backgrounder/bg1539es.html.*
2. Letter to the Hon. Max Baucus, United States Senate, from HHS Secretary Michael Leavitt, December 4, 2007.
3. "Medicare Advantage: Private Health Plans in Medicare," Congressional Budget Office, June 28, 2007, p. 3, at *www.cbo.gov/ftpdocs/82xx/doc8268/06-28-Medicare_Advantage.pdf.*
4. "Overview of the Medicare Advantage Program," Centers for Medicare & Medicaid Services, May 2007, p. 2, at *www.cms.hhs.gov.*

comes. Such a policy would worsen overregulation without improving quality.

The decisions that drive spending and quality of care are made on an individual level. The best way to promote competition and drive value is by giving patients direct control over their health care resources through a system of defined contributions and by allowing doctors and other medical professionals to set prices above Medicare fees. For example, physicians should be allowed to "balance-bill" patients for fees above those set by Medicare. Such individual choice would create patient demand for transparency on cost and quality of services and physicians would have a compelling incentive to deliver value.

Conclusion. Congress is about to undergo its annual ritual of preventing deep cuts to Medicare physician payments. However, Members also have the opportunity to reform the system. Failing to do so—by passing a one-year fix or by piling on more spending targets, administered prices, and regulations—would seriously jeopardize access to quality health care for seniors and other Medicare beneficiaries.

Congress should pass reforms that introduce market forces into the decision-making of individual patients and providers. Consumer choice and competition would significantly improve both the value of services and the long-term viability of the Medicare program.

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