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The Baucus Health Bill: A Medicare Physician Payment Shell Game

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My colleagues, this is our opportunity to make history. Our actions here, this week, will determine whether we are courageous enough and skillful enough to change things for the better.

—Senator Max Baucus, addressing the Senate Finance Committee on September 22, 2009

For all of the bold talk of reform, the provisions of the Senate Finance Committee bill are simply more of the same. This is evident in the way the committee is evading the systemic problems that Congress created with its updates to its flawed Medicare physician fee schedule.

Since the federal government apparently cannot ensure beneficiary access in the current Medicare program—and since government price controls like those used in Medicare do not work—trapping more Americans into such a system through a government health insurance plan does not make sense.

Medicare Payment Update. Medicare reimburses doctors and other medical professionals for their services according to a congressionally created fee schedule that is annually adjusted by the Sustainable Growth Rate (SGR) formula. Enacted in the 1990s, the SGR is primary evidence of how Congress tries and ultimately fails to "bend the curve" of the health care costs in Medicare.

The idea is relatively simple: If Medicare spending grows faster than our overall economy (which is almost always the case), then payments to Medicare providers are to be reduced proportionately to keep expenditures in line over a period of time. Each year, the Centers for Medicare and Medicaid Services estimates how much the physician fee schedule update will have to be reduced the following year in order to meet the target Medicare expenditures on physician payment. The 2010 update, for instance, reflects expenditures from April 1, 1996, to December 31, 2009.

A Political Volcano. If the SGR update goes into effect in 2010 as planned under current law, it will result in massive Medicare payment cuts. But every year, Congress—under both Democratic and Republican leadership—routinely blocks the cuts from going into effect for a year or two at a time. At the same time, House and Senate leaders have left intact the underlying requirement to keep doctor payment below the rate of GDP growth.

Subsequently, the necessary cumulative cut in Medicare payments grows bigger. Without a change to current law, payments to physicians would be reduced by 21.5 percent as of January 1, 2010, and

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by an additional 5.5 percent each year from 2011 through 2014 (and a small reduction in 2015).[1]

The Baucus Proposal. In his opening statement to the Senate Finance Committee on September 22, Chairman Baucus acknowledged the failure to address the problem: "On one point, I want to acknowledge up front that we did not do as much to correct the payment of doctors under the incredibly misnamed 'Sustainable Growth Rate.' The SGR needs to be fixed permanently."[2]

But instead of fixing the SGR, the Senate Finance Committee bill repeats the prior pattern by providing a payment increase for 2010 and then pretending it did not happen. The reason for this one-year change in the update is obvious: Fixing the problem long-term would cost $200 billion over 10 years.[3] Steny Hoyer (D–MD), the House majority leader, rightfully called the Senate Finance Committee proposal a façade.[4]

Earlier this summer, the American Medical Association told its members that Congress would "erase" the SGR problem.[5] Fat chance.

The Price of Price Controls. The SGR issue should be appropriately viewed as a microcosm of current efforts to overhaul the health care system. The inclusion of the SGR provisions in the Senate and House bills is a tactical admission that Medicare beneficiaries' access to care is being threatened—potentially a form of rationing. Two years ago, when proposed SGR reductions were more modest than they are now, a poll of physicians found that 60 percent would limit the number of Medicare patients they accept and 14 percent would stop seeing Medicare patients entirely if these cuts went into effect.[6]

The SGR does not even accomplish the objective it was created to achieve: to bend the cost curve in Medicare. Payments to physicians continue to exceed overall economic growth. Two years ago, Dr. Cecil B. Wilson testified that "spending targets cannot achieve their goal of restraining volume growth by discouraging inappropriate care. Spending targets apply to a whole group and, therefore, do not provide an incentive at the individual physician level to control spending. In addition, they do not distinguish between appropriate and inappropriate growth because they apply across-the-board to all services. In addition, spending target systems are based on the fallacious premise that physicians alone can control the utilization of health care services, while ignoring patient demand, government policies, technological advances, epidemics, disasters, and the many other contributors to volume growth."[7]

Special Interest Lobbies. In addition to the budget problem, fixing the SGR poses a problem for seniors as well. Physicians are paid out of Medicare Part B, the Supplementary Medical Insurance Trust Fund (SMI) portion of Medicare. Even though SMI is heavily subsidized by taxpayers, non-disabled Medicare enrollees are required to pay 25 percent of Part B costs. (Originally, beneficiaries paid 50 percent of the costs.) So if physician payments go up, the cost of the entire program goes up, increasing the amount of the 25 percent share that beneficiaries must pay.

1. *2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 12, 2009, p. 22, at *http://www.cms.hhs.gov/reportstrustfunds/downloads/tr2009.pdf* (September 24, 2009).
2. Press release, "Opening Statement of Senator Max Baucus (D–Mont.) at Today's Mark-Up of the America's Healthy Future Act," September 22, 2009, at *http://finance.senate.gov/hearings/statements/092209mb.pdf* (September 25, 2009).
3. Douglas W. Elmendorf, director, Congressional Budget Office, letter to Charles B. Rangel, chairman, Committee on Ways and Means, U.S. House of Representatives, July 17, 2009, at *http://www.cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf* (September 25, 2009).
4. Corey Boles, "Rep Hoyer Calls for 10-Year Fix for Medicare Payments," Nasdaq.com, September 22, 2009, at *http://www.nasdaq.com/aspx/stock-market-news-story.aspx?storyid=200909221654dowjonesdjonline000425&title=update-rep-hoyer-calls-for-10-year-fix-for-medicare-payments* (September 25, 2009).
5. American Medical Association, "AMA Support for H.R. 3200: Answers to Frequently Asked Questions," July 20, 2009, at *http://www.dcmsonline.org/HR3200FAQs_72009_AMA.pdf* (September 24, 2009).
6. Medical News Today, "60% of Physicians Would Limit Number of New Medicare Patients If Scheduled Payment Cut Is Enacted, AMA Survey Finds," June 7, 2007, at *http://www.medicalnewstoday.com/articles/73237.php* (September 24, 2009).
7. *Ibid.*

Congress enacted a temporary "hold harmless" provision to shield most seniors from a premium increase in 2010 because they will not receive an increase in their Social Security benefits. The cost, however, is passed along to other Medicare beneficiaries. Of course, now that that reality approaches, Congress is considering spending another $2 billion to pick up the tab.

Central Planning Failures. As SGR and the history of Medicare demonstrate, the federal government has constantly intervened in the payment systems and increased massive cost shifting. The classic scenario is constantly repeated: Politicians over-promise (more benefits, lower costs to the beneficiary), the budget hemorrhages, politicians apply a tourniquet to stop the fiscal bleeding, and the short-term fixes create even greater long term problems.

History, not hysteria, is why so many Americans (especially seniors) are skeptical of the political promises of more while achieving budget neutrality. Government cannot deliver more services for less than the value of what is being provided. Government surpasses the private sector only in its ability to hide the true cost by forcing someone else to pick up the tab. Someone has to pay, which means politicians are constantly trying to pass the burden around like a hot potato among providers, beneficiaries, current taxpayers, and future taxpayers. Whoever is left with the unwanted cost protests, and the contest starts all over again.

The very idea that government is more efficient than the private sector is comical. Why did so many state and local governments get out of the direct delivery of health care services in the 1960s and 1970s? Because of government inefficiencies.

Medicare's SGR problem is another chapter in the big book of government central planning, an epic failure and a fountain of unintended consequences.

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