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Doctors, Patients, and the New Medicare Provisions

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Abstract: *The Patient Protection and Affordable Care Act (PPACA) is the most consequential social legislation of our generation. Because this law directly affects literally every American citizen through the unprecedented imposition of individual and employer mandates and regulates in a highly prescriptive fashion the financing and delivery of health care in the United States, it will fundamentally alter the relationship between individual Americans and the federal government. It will also alter the relationship between the national government and the governments of the several states. Unless it is repealed, it will negatively affect the character and quality of American life for generations to come.*

We are in the early stages of an eight-year implementation of the Patient Protection and Affordable Care Act (PPACA), the most consequential social legislation of our generation. Because this law directly affects literally every American citizen through the unprecedented imposition of individual and employer mandates and regulates in a highly prescriptive fashion the financing and delivery of health care in the United States, it will fundamentally alter the relationship between individual Americans and the federal government. It will also alter the relationship between the national government and the governments of the several states. Unless it is repealed, it will profoundly affect the character and quality of American life for generations to come.

In short, this law is historic, transformational, and profoundly troubling.

Talking Points

- The Patient Protection and Affordable Care Act affects every American citizen through the unprecedented imposition of individual and employer mandates and regulates the financing and delivery of health care in the United States.
- America's households control only a tiny portion of total health care spending, mostly in out-of-pocket spending for health insurance which is purchased on their behalf and designed by employers, managed care executives, or government officials.
- Ideally, individuals and families should control the flow of dollars in health care as they do in virtually every other sector of the economy.
- Individuals and families should be able to pick health plans and medical professionals that support or at least accommodate their ethical, moral, and religious convictions, especially in sensitive matters dealing with the beginning and end of life.

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LEADERSHIP FOR AMERICA

I would like to confine my remarks today to the impact of certain provisions of the law on the delivery of care by physicians and the goal of securing value to patients in the financing and delivery of medical services. This focus is particularly appropriate in light of the President's recess appointment of Dr. Donald Berwick as the Administrator of the Centers for Medicare and Medicaid Services (CMS). Dr. Berwick has had a distinguished academic career and is well known and respected as a prominent health policy analyst. But the wide appreciation of his academic achievements among health policy specialists does not necessarily signify broad agreement with his views.

One cannot get more of something by paying less for it. Thus, continued downward adjustments to reimbursement can indeed limit the supply of medical services. That is a form of rationing.

Following his nomination, Dr. Berwick's favorable remarks on the performance of the British National Health Service (NHS) and its restrictions on the supply of medical services—which he has favorably described as "rationing with eyes open"—have come to light and have justifiably interested members of the Senate and the public at large in his views on these matters. Hopefully, the United States Senate will have the opportunity to explore those views in more detail and Dr. Berwick will be afforded the well-deserved opportunity to clarify his position on a number of these issues and dispel any misconceptions or misunderstandings that have arisen as a result of the publicity surrounding his earlier remarks.

In fact, the recent media attention to Dr. Berwick and his views on rationing or the performance of Britain's NHS misses a much larger and far more consequential point. The personality of the CMS Administrator or the Secretary of HHS is of secondary importance to the legal framework that Congress itself has erected over the years through thousands of pages of statutory text, which has generated tens of thousands of pages of regulatory interventions into the financing and delivery of health care.

Medicare Cost Control

Medicare is an entitlement program with a defined set of medical benefits. Congress defines the benefits and specifies the reimbursement for Medicare benefits and medical treatments and procedures. It does so through various formulas for administrative payment. Under the terms and conditions of such an entitlement, government officials cannot control demand for these benefits; they can only control the supply. Cost containment therefore normally takes the form of downward adjustments to reimbursement.

One cannot get more of something by paying less for it. Thus, continued downward adjustments to reimbursement can indeed limit the supply of medical services. At the end of the day, that is a form of rationing.

Dr. Berwick is to follow the law under the authority of the Secretary and develop and enforce the regulatory regime that Congress has authorized. It is a complex system where control of supply through price regulation is the conventional means of cost containment. This opens up a larger question for the future of our doctors and their patients: Exactly how much control do we wish to transfer to federal officials, and how much do we wish to retain for doctors and their patients?

This is the crux of the matter, and this is at the center of our continuing national health care debate.

Mixed Messages

Our problem is that the American people are getting mixed messages. This is undermining public trust. For example, in his June 15, 2009, speech to the American Medical Association, President Obama said:

> I know that there are millions of Americans who are content with their health care coverage—they like their plan and they value their relationship with their doctor. And that means that no matter how we reform health care, we will keep this promise: if you like your doctor, you will be able to keep your doctor. Period. If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what.

The President's attempted reassurance on these points has been unpersuasive. Indeed, the recent

congressional expansion of the regulatory power of the Medicare bureaucracy appears to contradict what was once thought to be a settled principle formally embodied in the original Medicare law itself. Under Section 1801 of Title XVIII, Congress established clear boundaries for federal officials, basically barring them from interfering with or supervising the practice of medicine:

> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

The President has steadfastly insisted that Americans will be able to keep their relationship with their doctors. While the professional independence of physicians is a common impression among ordinary Americans, in reality, that independence has been seriously eroded.

For centuries, physicians have understood their own role to be an application of their knowledge, skills, and abilities in the service of the interests of individual patients, which is nothing less than an ethical imperative overriding other considerations. Under the traditional Hippocratic Oath, physicians are to be servants of their patients, and nothing should come between the physician and his patient. But as a cultural matter, the force of the traditional oath has been steadily weakened; many medical schools don't even administer it or administer a watered-down version of it. Consider it a quiet revolution in medical ethics, and many Americans, as patients, are not even aware that it has even taken place.

As for the original congressional statutory restrictions on federal interference in medical practice in the Medicare program, that has also been progressively eroded both in law and in regulation.

While the professional independence of the medical profession is a common impression among ordinary Americans, in reality, that independence has been eroded.

For example, under Section 4507 of the Balanced Budget Act of 1997, Congress enacted for the very first time a unique statutory restriction on the ability of doctors and Medicare patients to contract privately with each other for the delivery of medical services outside of the Medicare program. Under that provision, doctors could privately contract if they notified the Secretary of their intent to enter into such a contract, submitted the notification within 10 days, and agreed to forgo all other Medicare reimbursement from all other Medicare patients for a period of two years. No such restriction was applied to any other government program, including Medicaid.[1]

Impact of the New Medicare Provisions on Doctors

Under the PPACA, there are well over one hundred sections of the law dealing with various aspects of the Medicare program, ranging from changes (mostly reductions) in payment for hospitals, skilled nursing homes, and home health care agencies to major reductions in payment for Medicare Advantage plans. Several provisions have direct impact on the practice of medicine: improvements in the Physician Feedback Program (under Section 3003), where the Secretary is to provide doctors reports on treatment resources used in episodes of care; the addition of a "quality" of care modifier to the formula governing the Medicare physician fee schedule (under Section 3007); and a "Physician Compare" Internet Web site that will provide public information by 2013 on how a Medicare physician is performing. In its April 21, 2010, report, analysts at the Congressional Research Service observe that:

> [The law] makes several changes to the Medicare program that have the potential to affect

1. For a discussion of this bizarre provision, see Robert E. Moffit, "Congress Should End the Confusion Over Medicare Private Contracting," Heritage Foundation *Backgrounder* No. 1347, February 18, 2000, at *http://www.heritage.org/Research/Reports/2000/02/Congress-ShouldEnd-the-Confusion-Over-Medicare-Private-Contracting.*

physicians and how they practice in ways both small and large, immediately and over time. While some of the provisions have clear and direct consequences, for instance altering physician reimbursement right away, others have the potential to influence how physicians might practice in the future by changing the incentives to encourage improvements in the organization and delivery of care.

Whatever one thinks of these provisions, the practice of medicine will change because of them, as will the relationship one has with a physician. All Americans should recognize that the imposition of these changes is, in fact, a federal supervision of medicine that was explicitly rejected when Medicare was enacted in 1965.

The health law will not materially improve the prospects of the medical profession. Aside from the authorization of state pilot programs to address deficiencies in medical malpractice law, which states can conduct on their own, the medical liability problems that confront physicians in many states will remain. Beyond that, administrative payment for doctors and other medical professionals under Medicare and Medicaid, a deepening source of frustration for physicians, is re-entrenched with the recent federal program coverage expansions.

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Nowhere is the problem more acute than with the operation of the Medicare Sustainable Growth Rate (SGR) formula for updating physicians' Medicare payment. Under that formula, if Medicare physician payment exceeds the growth of the economy, physician Medicare payment is automatically reduced by a proportional amount.[2] While the congressional leadership has indicated a strong desire to repeal the current Medicare SGR payment update formula, it is still unclear how they intend to do it without saddling taxpayers with a big increase in the federal deficit over the next 10 years and beyond.

With congressional enactment of another temporary "doc fix," increasingly demoralized physicians will only face the same problem again. Recent congressional actions to block an estimated 23 percent Medicare payment cut in December of 2010 will only mean that doctors will face even higher Medicare payment cuts in the future. Meanwhile, the Association of American Medical Colleges projects a shortage of 150,000 physicians within the next 15 years, while 15 million seniors will enroll in Medicare over the next 10 years.

If millions of ordinary citizens thought for one moment that they were going to get the kind of private insurance that their neighbors have, they are in for a rude awakening.

Based on Congressional Budget Office (CBO) and Centers for Medicare and Medicaid Services estimates, the new law is expected to significantly increase the number of citizens with health insurance coverage. CBO projects coverage to jump from 84 percent to 93 percent of the population.

This reduction in the number of the uninsured, however, is based on the assumption that the individual and employer mandates will be enforced and will work as they are intended to work—a *big* assumption. With the individual mandate, this could be a tricky process, fraught with potential for ineffective IRS enforcement, serious adverse selection in the health insurance markets, higher costs, and related unintended consequences.

For physicians, the insurance coverage expansion is a mixed blessing. Official estimates project that roughly half of all the newly covered persons over the next 10 years are going to be covered under Medicaid, a poorly performing welfare program with a reputation for delivering low quality of care. Millions of lower-income Americans will be confined to Medicaid, and, beginning in 2014,

2. For a discussion of the SGR, see John A. O'Shea, "The Urgent Need to Reform Medicare's Physician Payment System," Heritage Foundation *Backgrounder* No. 1986, December 5, 2005, at *http://www.heritage.org/Research/Reports/2006/12/The-Urgent-Need-to-Reform-Medicares-Physician-Payment-System.*

states are going to be required to enroll them. If millions of ordinary citizens thought for one moment that they were going to get the kind of private insurance that their neighbors have, they are in for a rude awakening.

Medicaid is the fastest-growing component of America's welfare system. As noted, it delivers low-quality care. The gaps in outcomes between private coverage and Medicaid are big, especially for cardiac, cancer, and even pediatric care. It also pays doctors and hospitals poorly. Toward the end of 2008, the Lewin Group reported that Medicaid nationwide paid physicians, on average, 56 cents on the private-sector dollar, which is why so many physicians have refused to take Medicaid patients or see new ones.

When I served on the Maryland Health Care Commission in 2003, our career staff did a study of Maryland physician payment and found that, on average, our Medicaid physician reimbursement often did not even cover the cost of providing the medical services. When Medicaid patients entered the physicians' waiting rooms, the physicians lost money. While there is a scheduled two-year increase in Medicaid reimbursement for primary care physicians, there is no structural change in the new law benefiting all physicians or altering the dynamics of the current Medicaid payment system, especially Medicaid patients' high usage of hospital emergency rooms for non-urgent care.

According to the Centers for Disease Control (CDC), Medicaid enrollees use the emergency room for non-urgent care at twice the rate of the uninsured and four times the rate of those with private insurance. So if you think we have problems with hospital room overcrowding now, just wait. According to former CBO Director Douglas Holtz-Eakin, the additional visits to the emergency room will generate tens of millions of visits and add an additional $36 billion to the nation's health care bill.

Right now, doctors and hospitals have no choice but to shift costs from public programs to the private sector, thus hiking premiums for private family coverage. If private insurers think they have problems with the tens of billions of dollars in Medicare and Medicaid cost shifting now, they have seen nothing yet.

With regard to the medical profession, there are bigger challenges ahead beyond payment or liability issues. As noted, under the original Medicare law, federal officials were explicitly forbidden to interfere with the practice of medicine. With the new law, it is not at all clear how physicians will be able to retain their traditional autonomy in the delivery of care, particularly under new compliance and reporting requirements related to the provision of quality of care, as determined by federal officials, and the existing restrictions on private contracting and balanced billing.

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For example, under Section 3403, there will be a 15-member independent payment advisory board to make Medicare payment policy. The board's task is to make recommendations to reduce the per capita growth rate in Medicare spending. Unless Congress enacts alternatives to effect the same level of savings, the Secretary and, presumably, the CMS Administrator are to implement the board's recommendations.

Unlike much of the broad grants of authority to the Secretary of HHS, this statutory language is uncommonly prescriptive. By 2015, Medicare payment is to grow at the rate of health care inflation. By 2019, it is to grow at GDP plus 1 percentage point. In the past 20 years, CBO estimated that Medicare's average annual rate of growth was 8 percent.

But consider this: The average annual rate of inflation for the period 1990 through the end of 2009 was approximately 3 percent, and the average annual rate of medical inflation was 4.6 percent. Over the same period, the average annual GDP growth was 4.8 percent. The board can indeed cut reimbursements to doctors and other medical professionals to hit these ambitious savings targets, as measured by inflation and GDP.

However, to borrow an understatement from the CMS Actuary, the task of actually meeting the inflation and economic growth targets will be a "challenge." Expect significant payment cuts for medical

professionals. Curiously, hospitals, which account for the largest portion of Medicare spending, are exempt from the board's authority until 2019. It is hard to imagine that this process will not affect medical practice, especially if there are no safety valves for doctors and patients alike, such as the restoration of Medicare private contracting without the statutory and regulatory restrictions of the Balanced Budget Act of 1997.

Patients don't control the dollars, and the doctors don't control the conditions of care delivery under the new regulatory dispensation. If seniors thought that the traditional Medicare fee-for-service program was here to stay, they are mistaken.

Under Section 3002 of Title III, the law strengthens the Physician Quality Reporting Initiative (PQRI). The program is to improve the quality of care delivered to Medicare patients. If doctors report the specified quality data, meaning that they are complying with federal standards in the delivery of care, they get Medicare bonus payments. If they do not comply and report the required data, their Medicare payments are cut.[3] By 2015, the law makes participation compulsory for doctors in Medicare.

This amounts to physician compliance with government-defined quality standards. Whatever else this is, it is not a prescription for traditional physician autonomy, professional independence, or clinical innovation in the delivery of care. It is certainly a prescription for more time-consuming compliance with Medicare rules, which are multiplying with stunning rapidity. Worse, the monstrous statute itself is no sure guide as to how all of this will work out on the ground; the crucial details will be set forth in future regulations.

Under the PPACA, CMS officials will also be charged with designing 20 new payment systems for doctors. Under Title III, the statute specifically calls for the redirection of Medicare payment away from traditional fee for service, which serves about 77 percent of seniors today, in favor of salaried physician payments.[4]

Of course, there is nothing inherently wrong with radical new payment systems, such as "bundling payment" for medical services (paying for episodes of care for a medical condition rather than for units of medical service) as conservative and liberal health policy analysts have both suggested, but we should recognize that under the current Medicare structure, doctors and their patients ordinarily have little control over the kinds of payment arrangements that will exist between them. Patients don't control the dollars, and the doctors don't control the conditions of care delivery under the new regulatory dispensation. If seniors thought that the traditional Medicare fee-for-service program was here to stay, they are also mistaken.

Paradoxically, many Members of Congress who supported enactment of the PPACA—responsible for record-breaking Medicare provider payment cuts, new layers of Medicare bureaucracy, and top-down payment changes—are often the same Members who oppose serious Medicare reform proposals to restructure the program in a patient-friendly fashion, based on personal choice and market competition, because such reforms would "end Medicare as we know it."

An Alternative Approach to Medicare Financing

The President and the authors of the Patient Protection and Affordable Care Act have focused heavily on the problem of securing value. Medicare "pay for performance" for physicians and "value based purchasing" of medical goods and services for

3. Under the PQRI, if doctors are properly complying and reporting, they will get a bonus of 1 percent of Medicare payment in 2011 and 0.5 percent in 2012, 2013, and 2014. Doctors who do not comply will face a 1.5 percent payment penalty in 2015, when the reporting program is mandatory, and a 2 percent payment penalty in 2016 and thereafter.
4. For a discussion of this provision, see Clete DiGiovanni and Robert E. Moffit, "How Obamacare Empowers the Medicare Bureaucracy: What Seniors and Their Doctors Should Know," Heritage Foundation *WebMemo* No. 2989, August 24, 2010, at *http://www.heritage.org/Research/Reports/2010/08/How-Obamacare-Empowers-the-Medicare-Bureaucracy-What-Seniors-and-Their-Doctors-Should-Know.*

hospitals is law, and the worthy objectives are to be achieved through superior planning and administration, as well as the manipulation of economic incentives through new forms of administrative payment. This is a classic top-down approach to health care financing and delivery.

If doctors control the delivery of health care, patients should control the financing.

There is a better way: bottom-up. Under this approach, the key element of health care reform would be to restore the traditional doctor–patient relationship and rearrange the financing of health care so that patients are the key drivers of reimbursement, not unaccountable third-party administrators or government officials.

Restoring the Doctor–Patient Relationship. For their part, the doctors and other medical professionals must do whatever is in their power to make the right diagnosis of the condition to be treated and prescribe the right remedy at the right time to cure disease. Doctors should be the key decision-makers in the delivery of health care, and if they are not the key decision-makers, policymakers need to make sure that they become the key decision-makers in the system.

That is where patients come into the equation. If doctors control the delivery of health care, patients should control the financing. So the key ingredient in creating a value-based health care system would be to transfer direct control of the flow of health care dollars to individuals. This would create a patient-centered, consumer-driven system. It would be the kind of system, based on real choice and robust competition, that would deliver what is of value to the patient, not value defined by either government officials or third-party administrators. At the end of the day, value in health care for an individual patient in a clinical setting can only be determined by that patient in direct consultation with his physician based on the best available information and informed consent.

Systemically, in both the public and the private sectors, we are far from that kind of a common-sense arrangement. Patients do not control the financing of health care. America's households, not government officials or employers, already pay 100 percent of health care costs, but America's households control only a tiny portion of total health care spending, mostly in out-of-pocket spending for health insurance which is purchased on their behalf and designed by third parties: employers, managed care executives, or government officials.

Those who control the dollars are those who call the shots. Ideally, individuals and families should control every red cent spent on health care as they do in virtually every other sector of the economy, where consumers make an exchange of dollars for goods and services of value to them.

The Fruits of Patient Empowerment

What would such a new approach mean for doctors and patients?

First, it would mean much greater personal choice over health options in both the public and the private sectors. In the public sector, it would mean that retirees would, for example, be able to carry their private health plans with them into retirement and secure a generous government contribution to offset their cost. In the private sector, individuals and families would have the opportunity, if they wished to do so, to own and control their health insurance policies, just like they own and control their own auto, life, and homeowners insurance, and be able to take their policies with them from job to job without a tax or regulatory penalty.

Second, it would mean much greater patient control over the financing of health options. Individuals would be able to buy the plans they want, the benefits they want, and contract with doctors and other medical professionals for the services *they* want at a price *they* wish to pay. This means that individuals would be able to pick health plans that provide them value for their dollars; they would know the price of medical services, and they would be able to compare performance and quality in an information-driven market.

Third, health plans and doctors and other medical professionals would compete on a level playing field. Government would not be in the business of picking winners and losers, setting different rules for different plans and groups, or encouraging or

discouraging the marketing or promotion of different health care options.

Finally, individuals and families would be able to pick health plans and medical professionals that support or at least accommodate their ethical, moral, and religious convictions. That is especially important in sensitive matters dealing with the beginning and the end of life.

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