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Obamacare and Medicare Provider Cuts: Jeopardizing Seniors' Access

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Under the Patient Protection and Affordable Care Act (PPACA),[1] Congress has enacted record-breaking Medicare payment reductions. Most of these are reductions in Medicare payment updates to non-physician providers. To a lesser degree, these reductions are attributable to certain health care delivery reforms.[2] The Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS), the agency that administers the Medicare and Medicaid programs, estimates an initial 10-year savings from the total set of Medicare changes amounting to $575 billion.[3]

However, conspicuously absent is any change in the flawed Sustainable Growth Rate (SGR) formula governing annual physician payment updates.[4] Congress routinely stops Medicare physician payment cuts from going into effect under current law. The Congressional Budget Office (CBO) estimates that a permanent "fix" to the broken physician payment formula would add $228 billion to the initial 10-year cost of the law[5] and that its enactment would worsen deficit projections over the next 10 to 20 years.[6]

Summary. The Secretary of the U.S. Department of Health and Human Services (HHS) will enforce Medicare payment reductions through changes in administrative payment formulas. Most changes are addressed in Title III of the massive statute, although others are scattered elsewhere. Some examples:

- Under Section 3401, Congress reduces Medicare payment updates for hospitals, skilled nursing facilities, home health agencies, and hospice care centers. Congress also modifies reimbursement formulas for specific medical services, including ambulance services, ambulatory surgical services, and laboratory services, as well as payments for certain durable medical equipment and supplies. Annual Medicare payment updates for these providers and services are usually based on two key factors: (1) the "market basket" indices (the prices of the goods and services that providers purchase in providing services to Medicare beneficiaries) and (2) inflation. PPACA further modifies the annual payment updates by including a "full productivity adjustment."[7] This modification links Medicare payment to measurable productivity gains in the private economy, including the manufacturing sector.[8] The effect of this change, plus changes in the market basket indices, is a downward adjustment in the annual Medicare payment for most of the institutions and services covered under Section 3401.[9] The payment reductions from these changes required by Section 3401will reach $156.6 billion over the period 2010–2019, according to CBO.[10]
- Under Section 3131, Congress makes payment changes for home health care services. The Sec-

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retary of HHS is required to reformulate Medicare home health payments to reflect the volume, mix, and intensity of services delivered to Medicare beneficiaries for episodes of care and, in determining payment, to factor in the "average cost" of providing care for these episodes. The law says the Secretary must also impose payment caps, but it allows for a 3 percent increase for rural home health care. CBO estimates that these changes will yield an initial 10-year savings of $39.7 billion.[11]

- Under Section 3133, the Secretary is required to change the Medicare formula for the Disproportionate Share (DSH) payment to hospitals. Beginning in fiscal year 2014, those payments must be reduced to equal 25 percent of what they would have been under previous law. Additionally, the Secretary is to incorporate relevant data on hospitals' care for the uninsured and the uncompensated care. Neither the Secretary's payment determination nor the factors that the Secretary uses for making these determinations are to be subject to administrative or judicial review. CBO estimates that these DSH payment formula changes would result in an initial 10-year savings of $22.1 billion.

CBO reports other Medicare payment changes that would yield modest 10-year savings: a reduction in hospital payment for excessive readmission ($7.1 billion) and the creation of Accountable Care Organizations, through which providers share savings from efficient care delivery ($4.9 billion).[12] Curiously, in sharp contrast to promised results, CBO reports little or no effect on Medicare spending from enacting such vaunted Medicare delivery reforms as "value-based purchasing" among hospi-

1. Congress cannot build sound market-based health care reform on the foundation of a flawed health care law. Therefore, the health care law must be repealed in its entirety.

   The House of Representatives has taken a major step towards full repeal of the Patient Protection and Affordable Care Act (PPACA—otherwise known as "Obamacare"). Until full repeal occurs, Congress must continue to focus on the core failures and consequences of PPACA and block its implementation to allow time to achieve repeal and lay the groundwork for a new market-based direction for health care reform.
2. Patient Protection and Affordable Care Act of 2010, Public Law 111–148, and Health Care and Education Reconciliation Act of 2010, Public Law 111–152.
3. Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010, p. 2.
4. Under the SGR, physician payment is tied to the performance of the general economy. If, in any year, physician payment outpaces the growth in the economy, the following year there is an automatic reduction in Medicare physician payment. The payment reduction postponements are cumulative, including those temporary fixes enacted twice in 2010. Thus, toward the end of 2010, the pending reduction would have amounted to 23 percent.
5. The Lewin Group, "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers," June 8, 2010, p. 31.
6. If the current SGR formula remains in place, resulting in sizable cuts in Medicare physician payments, the Lewin Group projects a deficit reduction of $85.9 billion over the period 2010–2019 and $338.8 billion over the period 2020–2029. If the SGR is "fixed" permanently, the federal deficit increases by $142.5 billion over the period 2010–2019 and by $345.3 billion over the period 2020–2029. See *ibid*.
7. Patricia A. Davis *et al.*, "Medicare Provisions in PPACA (PL111-148)," Congressional Research Service *Report for Congress*, April 21, 2010, p. 60.
8. *Ibid.*, p. 5.
9. For example, Medicare home health agency "market basket" updates are to be reduced by 1 percent in 2011, 2012, 2013, and 2014, and a "productivity adjustment" is to be added in 2015. The Congressional Research Service (CRS) projects that these adjustments could slow the growth in Medicare home health payments to zero. *Ibid.*, p. 8.
10. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to Nancy Pelosi, Speaker, U.S. House of Representatives, March 20, 2010, Table 5.
11. *Ibid.*
12. *Ibid.*

tals, the addition of a "value-based payment modifier" for the Medicare physician fee schedule, or new quality-of-care reporting requirements among physicians and other medical professionals.[13] Reduced payment to hospitals with excessive hospital-acquired infections or other complications generates an initial 10-year savings of just $1.4 billion.[14]

Impact. Medicare's administrative payment formulas are impressively complex, but they bear little relationship to economic reality. Enforcing PPACA changes will likely lead to unfavorable results.

Payment Reductions Threaten Seniors' Access to Care. "Providers for whom Medicare constitutes a substantive portion of their business," concludes the CMS Actuary, "could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries). Simulation by the Actuary suggests that roughly 15 percent of Part A providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments."[15]

Projected Medicare Savings Will Not Enhance the Program Solvency. According to the CMS Actuary, "The combination of lower Part A costs and higher tax revenues results in a lower federal deficit based on budget accounting rules. However, trust fund accounting considers the same lower expenditures and additional revenues as extending the exhaustion date of the HI [Hospital Insurance] trust fund. In practice, the improved HI financing cannot be simultaneously used to finance other federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions."[16]

CBO emphasized this key point in a January 22, 2010, letter to Senator Jeff Sessions (R–AL): "Unified budget accounting shows that the majority of the HI trust fund savings under PPACA would be used to pay for other spending and therefore would not enhance the ability of the government to pay for future Medicare benefits."[17]

Medicare Payment Reductions Are Unlikely to Survive. Without "escape valve" provisions to guarantee ease of access to care through the private sector, Medicare payment reductions are unlikely to survive. As the CMS Actuary has remarked, "The long-term viability of the Medicare update reductions is doubtful."[18] He reasons that the resultant 10 years of "sustained" payment reductions from mandated formula changes would cause payments to Medicare providers to grow more slowly than will the cost of providing the medical services. This would not only reduce providers' profit margins but also discourage their participation and thus threaten patient access to care.[19] Meanwhile, pressure on Congress would likely build to stop or reverse the reductions.

Likewise, in referring to the new law's Medicare payment policies, CBO warns, "The reconciliation proposal and H.R. 3590 would maintain and put into effect a number of policies that might be difficult to sustain over a long period of time."[20]

A New Direction. Budget and health policy analysts know that a congressional failure to come to

13. *Ibid.*
14. *Ibid.*
15. Foster, "Estimated Financial Effects," p. 10. The Actuary questions the applicability of private sector productivity measures for measuring productivity in Medicare payment.
16. *Ibid.*, p. 9. Likewise, CRS concludes, "Reductions in Medicare expenditures can be used to extend the solvency of the HI trust fund *or* used to offset the costs associated with expansion of health insurance coverage; using both accounting methods at the same time would result in double counting a large share of those savings." Davis *et al.*, "Medicare Provisions in PPACA," p. 14.
17. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to Jeff Sessions (R–AL), United States Senate, January 22, 2010, p. 3.
18. Foster, "Estimated Financial Effects," p. 21.
19. *Ibid.*, pp. 9–10.
20. Elmendorf, letter to Pelosi, p. 14.

grips with Medicare and other entitlement spending is ruinous for current and future generations. Using Medicare savings to offset the creation of new and unsustainable entitlements is no way to reform Medicare.

If Congress is serious about improving Medicare and restraining Medicare spending, it is essential that Congress start with a *permanent* SGR correction without adding to the deficit. In addition, Congress would be wise to end the 1989 restrictions on physicians' ability to balance bills for medical services above the prescribed Medicare payment and statutory and regulatory obstacles that inhibit seniors from going outside the Medicare program and contracting privately with physicians of their choice to secure the medical services they want and need.[21] If a robust private medical market is an option for British citizens under a government-run system, there is no reason why Congress should restrict the medical freedom of American seniors.

Finally, Congress should initiate a defined contribution system that allows seniors to take their private coverage into retirement while securing a generous government contribution toward its cost.[22] These changes would lead to the lasting structural reforms that are necessary to ensure that seniors have choice plus stable and reliable coverage and care.

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21. For an historical perspective on this issue, 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.*
22. For an overview of how to accomplish this, see Robert E. Moffit and James C. Capretta, "How to Fix Medicare: A New Vision for a Better Program," Heritage Foundation *Backgrounder* No. 2500, December 13, 2010, at *http://www.heritage.org/Research/Reports/2010/12/How-to-Fix-Medicare-A-New-Vision-for-a-Better-Program.*