Health Policy in Medicine: Inside the Beltway

The "Doc Fix"

by Eugene Rich, MD, FACP

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In the midst of Senate leadership efforts to meld two Committee-passed bills into comprehensive health care reform, Majority leader Harry Reid recently tried, and failed, to pass legislation to accomplish part of what Beltway insiders call "The Doc Fix". This legislation would have repealed an arcane formula, the SGR ("Sustainable Growth Rate"), implemented in 1998 to cap how quickly Medicare spending on physicians' services could grow. An early attempt by Congress to control the overall rate of growth of Medicare spending, this strategy was aimed at physicians (and other clinicians) who are predominately paid on a "per-encounter" (i.e. fee-for-service) basis. This type of piece-work payment has long been suspected to accelerate health care spending, and thus was deemed by policy makers a prime target for cost controls.

Unfortunately the SGR approach, applying as it does to all clinicians paid under the Medicare fee schedule regardless of their individual patterns of appropriate or profligate utilization, did not moderate clinician behavior. When spending did indeed grow faster than allowed under the formula (which had been set at roughly GDP growth plus inflation), Congress was reluctant to continue to impose the mandated annual penalty. So for the past seven years, under both Republican and now Democratic Congressional majorities, clinicians billing Medicare have not been subjected to the revenue penalties mandated by the SGR. Worse yet, when this forgiveness was first given, lawmakers did not fund these additional payments. Instead they passed legislation that stipulated if physician spending did not come back in line with the SGR formula in the future, then the full cost would have to be recouped by future cuts in Medicare reimbursement. Congressman Pete Stark (for whom I worked on this problem in 2007) decried this behavior as "kicking the can down the road." In December of 2007 the House and Senate Democrats reached a compromise approach to fix the SGR, but the money was to be found from the extra payments Medicare gives to private "Medicare Advantage" health plans. The Bush administration indicated this approach would earn a White House veto- so, much to Chairman Stark's disappointment, the "can" got kicked down the road in December 2007 as well. The problem was also deferred in 2008; so now, if the SGR formula isn't fixed by Dec 31, physicians and other clinicians will get a 21% cut on each fee, with an additional 5% fee cut each year thereafter. Obviously not a great way to start health care reform!

So why not fix this formula? Well the first problem is that the accumulated cost of all the previous deferrals is now nearly $250 billion. And under the rules of Federal budget accounting, eliminating the SGR as part of comprehensive Health Care Reform would increase the price tag for this legislation. If the Senate Finance Committee health reform legislation (which was projected to cost $829 billion) also resolved the SGR, it would now cost nearly $1100 billion over the next decade, far over President Obama's threshold of $900 billion investment in health care reform. Note that committing this $250 billion dollars to the "Doc Fix" would add no new benefits for any Medicare recipients nor reduce the rolls of the uninsured. Therefore, to new members of Congress trying to meet the needs of current voters, this seems a high price to pay to resolve an old problem.

Thus the Senate leadership tried to absorb the cost of eliminating the SGR separate from health care reform. Because this is an oddly technical form of cost in Capitol Hill accounting (no one is actually getting $250 billion next year, and no one has yet actually borrowed that amount over the past 10 years), the thinking was to make this correction separate from health care reform, so the numbers would not get drawn into the reform debate. This strategy obviously failed, with numerous Senators who had repeatedly voted to kick this particular can, now declining to pick it up and put it in the legislative trash.

Unfortunately, eliminating this formula doesn't even really "fix" physician (and other clinician) payment. The $250 billion cost assumes that physicians (and their employees) would be satisfied receiving the

same Medicare payment in 2019 that they are now receiving in 2009. To eliminate the SGR and guarantee cost-of living adjustments in fees would cost several times this amount.

This proposed (and once again deferred) Doc Fix is understandably seen by physicians as a long overdue correction that would clear the way for more comprehensive physician payment reform. Even so, the latest health care reform legislation released by House leadership this week also pulls the cost of the SGR out of the health care reform legislation (and debate), presumably in order to meet President Obama's spending limits. While the House Health Reform proposal does outline some strategies for reforming physician payment, it does not offer a clear path forward or assurances of future savings. These strategies are proposed as "pilot programs" meaning that CMS (Centers for Medicare & Medicaid Services) could implement the reform in a limited way but would have the legal authority to extend it across the land if the strategy met quality and efficiency goals. The options include medical home payments adding monthly care coordination support basic primary care functions, and revised payment for "accountable care organizations" (networks of clinicians affiliated with hospitals and other facilities to manage the care of a large group of Medicare beneficiaries). CMS is also to experiment with bundled payments, for example, paying a fixed amount for a year of specialized care after a heart attack rather than paying separately for each physician visit, heart scan and hospital stay.

Although payments for personal physician services account for only 21% of total health care costs, physician decisions account for perhaps 80% of total health care spending. Furthermore our complicated and fragmented delivery system contains vast opportunities for reduced errors and better use of both technology and talent. Therefore providing physicians and other clinicians the right incentives to work effectively in coordinated teams, implement information systems, and practice more patient-centered, evidence- based medicine will be essential to successful health care reform. That will be the real "Doc Fix."

For more on my work in 2007 on the Doc Fix, see my Health Affair Blog article from 2008.

Eugene C. Rich MD FACP
Scholar in Residence
Association of American Medical Colleges
Professor of Medicine, Creighton University School of Medicine
Faculty Associate, Center for Health Policy and Ethics
email: richec@creighton.edu