NATIONAL CENTER FOR POLICY ANALYSIS

Fix The Flawed Medicare Doc Fix

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On March 26, an overwhelming bipartisan majority in the House of Representatives voted for the Medicare Access and CHIP Reauthorization Act (MACRA). Secretly negotiated between Republican and Democratic leaders, this so-called Medicare "doc fix" doubles down on Obamacare, adding $500 billion to the national debt and increasing federal government control of physicians' practices.

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Executive Summary

For over a decade, Congress has struggled with an inadequate formula to calculate Medicare payments to physicians. The formula results in an amount too low to ensure physicians will continue to see Medicare beneficiaries. At least once a year, Congress has to pass a short-term increase to Medicare physician payments to prevent fees dropping about 20 percent. The current boost expired on March 31, 2015, necessitating a rapid response.

MACRA is a poor doc fix for two major reasons:

- Less than four percent of its spending is offset by cuts to other government spending, resulting in an estimated $141 billion increase in cumulative budget deficits over 10 years, and $500 billion over 20 years. This is the first time since Congress began to struggle with the physician payment formula that it has abandoned budget neutrality, a commitment made previously by both parties.
- MACRA significantly increases federal control of the practice of medicine, in line with the ambitions of Obamacare. Doctors will face increasing requirements to comply with federal regulation in order to get paid. These will likely include greater reliance on government-certified Electronic Health Records, which have already proven to frustrate doctors and do nothing to benefit patient care, despite an investment of $30 billion taxpayer dollars.

Three options are available to reduce the shortcomings of MACRA and keep the door open to effective Medicare reform:

- A two-year doc fix, paralleling the extension of the Children's Health Insurance Plan in MACRA.
- Including MACRA in the pay-as-you-go (PAYGO) scorecards, requiring the president to pay for it with other funds.
- Finding offsets to pay for the $141 billion in MACRA spending that is not yet offset.

Introduction:

What Is The Problem with How Medicare Pays Doctors?

The doc fix is an attempted solution to a problem in the way Medicare pays doctors. In most cases, Medicare pays physicians for each service they perform, as described and priced in the Physician Fee Schedule (PFS). William Hsiao, the economist who designed this system, originally determined the fees as follows:

> He put together a large team that interviewed and surveyed thousands of physicians from almost two dozen specialties. They analyzed what was involved in everything from 45 minutes of psychotherapy for a patient with panic attacks to a hysterectomy for a woman with cervical cancer. They determined that the hysterectomy takes about twice as much time as the session of psychotherapy, 3.8 times as much mental effort, 4.47 times as much technical skill and physical effort, and 4.24 times as much risk. The total calculation: 4.99 times as much work. Eventually, Hsiao and his team arrived at a relative value for every single thing doctors do.[1]

Current law grants Medicare a certain amount of money every year to pay all claims submitted under the PFS. That money is divided among the claims submitted by physicians according to the relative value assigned to each procedure.

The total amount increases annually according to a formula called the Sustainable Growth Rate (SGR), which was established in 1997. Most importantly, the SGR depends on the change in real gross domestic product (GDP) per capita.[2]

The PFS is part of the Medicare Part B program, which is an explicit "pay as you go" system. Seniors pay one-quarter of the costs through premiums, and taxpayers pay the rest through the U.S. Treasury. The problem is that the amount is not enough. For example:

- If the growth in Medicare's payments to doctors in 2015 were limited by the SGR, the payments would drop by about one-fifth, and many would stop seeing Medicare patients.
- Since 2003, at least once a year, Congress increases the payments for up to one year. The latest was passed in March 2014 and ran through March 31, 2015, and was estimated to cost $15.8 billion.[3] This has happened 17 times since the SGR came into effect.

Congress has *never* allowed Medicare physician fees to drop as indicated by the SGR, and Medicare beneficiaries have *never* faced a crisis of access to doctors. As shown in Table I, payments to physicians under the PFS would cost about $778 billion over the next 10 years if the SGR applied, amounting to 19 percent of Medicare Part B spending and 8 percent of overall Medicare spending. This is referred to as the "baseline." However, the Congressional Budget Office (CBO) has also estimated a more realistic "policy alternative", in which Congress keeps boosting physicians' fees. This policy alternative would increase spending on fees by $142 billion over 10 years, amounting to 22 percent of Medicare Part B spending and 10 percent of overall Medicare spending.

About the Author

John R. Graham is a Senior Fellow of The National Center for Policy Analysis. He is the primary contributor to NCPA's award-winning Health Policy Blog, and writes a weekly column at Forbes.com. Canadian by origin, Graham has a unique insight into single-payer health systems. He also researches Health Information Technology, Medicare, Medicaid, the regulation of private insurance, and the effects of Obamacare on health care and the economy.

Graham received his M.B.A. from the London Business School (England) and his B.A. (with Honours) in Economics & Commerce from the Royal Military College of Canada. He is a Chartered Alternative Investment Analyst (CAIA Charterholder) and is an affiliate member of the CFA Society of Washington, DC, having completed all three levels of the CFA (Chartered Financial Analyst) program.

Why This Doc Fix, Now?

Fundamentally different than the previous 17 short-term increases to the SGR, MACRA jettisons the SGR entirely, and replaces it with annual increases at a fixed percentage rate. Table I shows MACRA would increase PFS spending by $176 billion beyond the baseline, almost one-quarter more than the CBO's policy alternative.

Temporary "Doc Fixes" Were Paid For. Some conservatives have argued that the *status quo* leads to an artificially low budget baseline. This is a fair criticism of the SGR. However, short-term increases to the SGR have been paid for by spending offsets. The success rate has been 98 percent, according to the Committee for a Responsible Federal Budget (CRFB).[4] The major blemish was in last year's one-year increase.

Some $4.9 billion of those offsets (about one-third of the total) were captured by advancing sequester cuts to Medicare — which had already been legislated — from 2024's calendar year to fiscal year, moving them forward by three months.[5] This brought them into the ten-year budget window the CBO uses. The CRFB rightly called this a gimmick.[6]

However, as far as budget gimmicks go, this was a misdemeanor. It was a small timing shift in the final year of sequestration cuts. It cannot be used again. Further, any gimmicks in a short-term increase are less harmful than gimmicks to offset legislation that puts spending on a permanent, upward trajectory — which is what MACRA does.

The Permanent "Doc Fix" Isn't Paid For. A permanent doc fix has long been the dream of both politicians and physicians' lobbyists. It would finally free politicians from having to search for money to pay doctors every year. This has become increasingly painful for politicians, who now revile the SGR as broken and unworkable. Their frustration grew because Congress used to believe it had to finance the short-term increases in PFS spending by reducing other spending to ensure budget neutrality. MACRA abandons this discipline.

MACRA was secretly negotiated by House Speaker John Boehner and Minority Leader Nancy Pelosi for two months.[7] Not a word of this deal was spoken of publicly while House and Senate Republicans debated their budget resolutions in public. Importantly, the House budget resolution for fiscal year 2016 embraced the so-called Ryan Medicare reform, which would improve Medicare for those entering the program in 2024 and subsequent years by giving them a much greater choice of health plans.[8] For years, President Obama has consistently attacked this proposal, and this year has been no exception.[9] MACRA also rejects this reform, which explains why President Obama has already indicated his eagerness to sign the new bill.[10] As a consequence, the House budget resolution looks like pantomime, while MACRA appears to be the real deal.

Problems with the Permanent "Doc Fix"

MACRA has two serious problems that make it a poor candidate to replace the SGR. First, it breaks the promise of fiscal responsibility both Republicans and Democrats made to the citizens. Second, it significantly increases federal control of the practice of medicine, continuing the momentum started by Obamacare.

Medicare Spending Under Different Scenarios ($ Billions), 2015-2025

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2015-2025
Medicare Total	626	671	681	698	775	829	888	995	1,026	1,053	1,183	9,424
Medcare Part B	270	289	295	303	336	361	388	435	451	465	524	4,117
Baseline Physician Fee Schedule	63	58	61	63	66	68	71	75	79	84	90	778
Policy Alternative	*6*	*11*	*11*	*11*	*12*	*13*	*14*	*16*	*16*	*16*	*18*	*142*
Baseline + Policy Alternative	69	69	72	74	78	81	85	91	95	100	108	920
MACRA Increase	*6*	*11*	*11*	*12*	*14*	*15*	*18*	*21*	*22*	*22*	*23*	*176*
Baseline + MACRA Increase	69	69	72	75	80	83	89	96	101	106	113	954

Source: Author's calculations from "March 2015 Baseline," Congressional Budget Office, March 2015; and "Cost Estimate and Supplemental Analyses for H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015," Congressional Budget Office, March 25, 2015.

Problem One: Breaking the Promise of Fiscal Responsibility. Despite increasing Medicare Part B premiums for higher-income households, MACRA makes almost no effort at finding offsets for its spending. CBO estimates MACRA will bring in less than $4 billion of revenue and add $141 billion to the deficit over the next 10 years.[11] CRFB estimates MACRA will increase the debt by $500 billion over 20 years.[12]

Further, after unpacking the gimmicks that underlie the estimate, the actual result is worse. As well as spending $176 billion on the PFS, the bill increases spending on the Children's Health Insurance Program (CHIP) by almost $40 billion. Yet, the CBO includes less than $6 billion in its estimate of the bill's costs; $34 billion of new CHIP spending simply vanished into thin air because much of it was *already* in the baseline.

Recall that the entire reason Congress has had to pass short-term increases in Medicare payments to doctors at least once a year for over a decade is that the budget baseline was determined by an unrealistic SGR.

CHIP, on the other hand, has a permanent baseline of $5.7 billion per year, even though current law only funds CHIP through 2015.[13] According the CBO:

- Current law provides no new budget authority for CHIP after 2015.
- Following the rule established in law for developing baseline projections of programs with such expiring funding authority, CBO's projections assume CHIP will continue to be funded so as to operate as it will under the law in effect immediately before the date after which its budget authority expires.[14]

The baseline derives entirely from the *assumption* CHIP will continue, even though there is no legal basis for that assumption. On the other hand, for increases to the SGR, which have been consistently re-authorized, there is *no* such assumption.

There is no economic logic behind the different treatment of the two programs in the baseline. However, it allowed the House of Representatives to extend CHIP at a fire-sale price and camouflage the true cost of the Medicare doc fix.

Although there is one good offset in the bill, its effect on revenues is trivial. Some medigap (or Medicare supplemental) plans increase Medicare spending by up to one third because they reduce patients' sensitivity to the cost of their care.[15] MACRA restricts first-dollar coverage for medigap plans. However, even that is not worth much: less than $1 billion, according to the CBO.[16] The president also has this reform in his budget (via a surtax on medigap premiums), and savings from his plan are almost $4 billion.[17] The reason for the difference is not completely clear, but appears to be mostly because the president's medigap reform starts in 2018, while MACRA's is delayed until 2020. Even in such a relatively small thing, the House of Representatives has *underbid* President Obama for budget savings!

Problem Two: More Government Control of the Practice of Medicine. Doug Badger, former Deputy Assistant to President Bush on Legislative Affairs, Staff Director of the Senate Policy Committee, and senior official at the U.S. Department of Health & Human Services, has concluded MACRA:

"… increases Medicare payments to physicians, largely by replacing one complicated and flawed formula with another. It directs the army of bureaucrats who populate CMS cube farms to soldier on with their futile, half-century-long quest to implement a workable system of administered pricing."[18]

Although MACRA increases payments to physicians overall, it also introduces yet undefined mechanisms to boost payments to some doctors versus others, based on bureaucratically defined measurements of quality and value. MACRA introduces two new measurement tools to govern how doctors practice: the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APM). Doctors will face an even higher burden of reporting and compliance than they do today:

"In addition to measures used in the existing quality performance programs (PQRS, VBM, EHR MU), the Secretary would solicit recommended measures and fund professional organizations and others to develop additional measures."[19]

This increase in federal control of the practice of medicine reinforces and extends the same approach imposed by Obamacare. This is best demonstrated by two statements made on the same day last month by two different politicians:

"Right now, Medicare pays doctors for every single treatment they

perform — with no regard for the patient's overall health. It rewards quantity, not quality, of care. And 10,000 baby boomers are joining Medicare every day, so costs are growing out of control."[20]

"And, relevant to the topic today, we're moving Medicare toward a payment model that rewards quality of care instead of quantity of care. We don't want the incentives to be skewed so that providers feel obliged to do more tests; we want them to do the right tests."[21]

The first paragraph is from a newspaper column written by Representative Paul Ryan, a conservative Republican, and Chairman of the House Ways & Means Committee, in support of MACRA. The second is from remarks made by President Obama in a speech on the fifth anniversary of his signing the Affordable Care Act (Obamacare).

As in Obamacare, the federal government will increase or decrease individual physicians' pay according to bureaucratic measures of quality and value. What is unclear is why Congress seeks to give the Administration more of this power. Secretary of Health & Human Services Sylvia Burwell is satisfied with the power current law (that is, Obamacare) already gives her over doctors. Just a week ago, she announced:

…… a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.[22]

It appears Secretary Burwell is way ahead of Congress on this issue. If those representatives who voted for MACRA believe the federal government is competent to regulate the practice of medicine in this way, they would cause less trouble by just leaving Secretary Burwell alone to pursue her business plan.

Further, part of this increased federal control over the practice of medicine is a resuscitation of the failed Meaningful Use requirements for Electronic Health Records (EHRs). This program has spent $30 billion to install EHRs, and has frustrated doctors and stymied innovation in health information technology.[23] The original $30 billion has almost all been spent; and making more of doctors' pay dependent on compliance with EHR mandates will simply re-impose a burden from which they are looking forward to escaping.

Fixing the Fix: Three Options

Because of the extremely short time before the SGR takes effect and doctors' pay is cut by about 20 percent, it is not possible to develop a new Medicare doc fix from the ground up. There are three options for fixing MACRA quickly.

A Two-Year Doc Fix. A shorter doc fix, which increases physicians' Medicare payments by no more than two years, has a number of positive features. It could be easily offset with other spending cuts (like the 17 previous short-term increases were), and immediately restore Congress' credibility on fiscal responsibility.

Further, MACRA extends funding for the Children's Health Insurance Program (CHIP) by two years, to September 30, 2017. If the doc fix were similarly limited to a two-year extension, instead of perpetually locking in spending, the gross cost of the change would drop from $175 billion to about $26 billion — easily paid for within the bill as written.

Another advantage of a time-limited doc fix that parallels the CHIP extension is that it would expire by the time a new president and Congress will have had plenty of time to debate both a replacement for Obamacare and real Medicare reform as proposed in the House budget resolution.

Include MACRA in the PAYGO Scorecard. Section 525 of MACRA exempts its spending from the PAYGO scorecard which would force the president to sequester funds. Simply removing Section 525 would allow the bill to pass without specific offsets but require Congress to find offsets later or the president to include MACRA spending in sequestration.[24] The advantage of this is that it is the easiest action to take under the current time pressure.

Find Offsets to Pay For MACRA. Finding offsets to pay for the entire doc fix is not as impossible as is often assumed. In 2014, the centrist Committee for a Responsible

Federal Budget (CRFB) introduced the PREP Plan, which described about $250 billion of offsets to pay for reforming Medicare physician payments.[25] The PREP plan was updated in March 2015.[26] CRFB has also proposed other Medicare savings outside the PREP plan.[27] Many of these are tax hikes not acceptable to conservatives, and some are spending cuts that over-rely on central planning (like Obamacare and MACRA do) or reduce prescription drug prices by degrading innovative drug makers' intellectual property.

Other savings proposed by the CRFB, some already in President Obama's budget, are mostly ignored in MACRA. I rank these in (a reasonable) descending order of acceptability to conservatives:

- Equalize payments for similar services performed in different settings ($30 billion) such as hospitals or physicians' offices;
- Modernize Medicare Part A and Part B cost-sharing rules (up to $80 billion) by reforming deductibles, coinsurance and copays;
- Restore "provider tax" limits to reduce the incentives for states to tax hospitals in order to distribute that money right back to providers and then receive a federal match for those taxes ($10 billion to $75 billion);
- Reduce Medicare's coverage of beneficiaries' unpaid debts to providers by 25 percent ($35 billion) or eliminate ($55 billion);
- Encourage low-cost physician-administered drugs ($10 billion) by paying a flat fee instead of a markup on drugs for injection;
- Introduce competitive bidding to determine payments to Medicare Advantage plans ($10 billion);
- Reduce excess subsidies to academic medical centers for indirect costs of Graduate Medical Education (GME) by ten percent ($10 billion) or phase out ($50 billion);
- Reduce preventable admissions and unnecessary complications ($10 billion) by increasing penalties for hospitals which have high readmission rates; or,
- Expand the use of bundled payments and Accountable Care Organizations in Medicare ($50 billion) that pay for episodes of care rather than individual services.

Even the first four on the list, if implemented to the hilt, would pay for a long-term doc fix.

Conclusion

MACRA is a bill that is fiscally irresponsible and will deepen government interference in patient-doctor relations. It was negotiated in secret and rushed through the House of Representatives without being properly vetted or debated. If implemented, fiscally responsible and patient-centered Medicare reform would be more difficult to achieve in future.

By the middle of April, doctors will face a significant pay cut if Congress does not pass an increase to the PFS. Three options are available to reduce the shortcomings of MACRA and keep the door open to effective Medicare reform:

- A two-year doc fix, paralleling the extension of CHIP;
- Including MACRA in the PAYGO scorecards; and,
- Finding offsets to pay for the $141 billion in MACRA spending that is not yet offset.

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