Center for Health and Economy

H.R. 574

Medicare Physician Payment Innovation Act of 2013

January 13, 2014

Medicare's payment rates to physicians are based on a fee schedule that specifies the payment for each type of service rendered. The relative fees are determined by the inputs required to produce each type of service, adjusted to account for geographical differences in input prices. Relative fees are translated into actual dollar amounts by applying a "conversion factor" that is updated every year.

In the Balanced Budget Act of 1997, Congress constrained the update factor by setting targets for Medicare expenditures, which, when exceeded, require reductions in the update. The mechanism of expenditure targets and adjustments to the payment rates is known as the "Sustainable Growth Rate" or SGR. Spending exceeded the target in 2001, and payment rates were reduced by 4.8 percent in 2002. However, since 2002, Congress has acted to delay the required cuts. Because the cuts are delayed for short periods and add up year after year, the Congressional Budget Office (CBO) estimates that Medicare payment rates for physician services is required by law to drop by about 24 percent in January 2014.[1]

The SGR is widely considered a broken method of cost-containment; large payment cuts could result in dramatic reductions in access for Medicare patients. As a result, numerous proposals to "fix" the SGR have appeared. In the 113th Congress, Ms. Schwartz of Pennsylvania and Mr. Heck of Nevada introduced H.R. 574, the "Medicare Payment Innovation Act of 2013."[2] In addition to repealing the SGR, H.R. 574 would make fundamental changes in Medicare's fee-for-service (FFS) payment mechanism. A summary of the bill follows:

1. Medicare fees would be frozen at 2013 levels in 2014.

2. From 2015 through 2018, the annual update for "qualifying practitioners" (over 60 percent of allowed charges accounted for by primary care services) would be 2.5 percent; for others it would be 0.5 percent.

3. Alternative delivery and payment models would be tested, with transitions to such models beginning no later than January 1, 2018. Two update factors would be created: one for physicians participating in new payment models; the second for those remaining in the FFS payment system.

4. Both conversion factors would be frozen for 2019.

5. Updates for FFS would be reduced by 2 percent in 2020, 3 percent in 2021, 4 percent in 2022, 5 percent in 2023, and zero percent in 2024 and thereafter.

6. Beginning in 2020, updates for physicians participating in the new payment models would be determined by Secretary of the Department of Health and Human Services with consideration for access to care and restrained spending growth. The conversion factors would not grow less than 1 percent or more than the percentage increase in the Medicare Economic Index (MEI), which measures the weighted average input prices required to produce each type of service.

[1] U.S. Congressional Budget Office, "Cost Estimate for H.R. 2810, Medicare Patient Access and Quality Improvement Act of 2103," September 13, 2013, available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr2810.pdf.
[2] The text of H.R. 574 is available at http://thomas.loc.gov/cgi-bin/query/z?c113:H.R.574:

There are a number of different proposals on how to best reform Medicare payments; the CBO analyzed one such proposal, H.R. 2810, from the House Energy and Commerce Committee, as increasing the federal budget deficit by $153 billion over the period from 2014 to 2023.[3] Differences between H.R. 574 and H.R. 2810 do exist (H.R. 574 is closer in kind to a proposal developed by the House Ways and Means Committee that builds on H.R. 2810), but in our opinion, the differences are not substantial. For example, all three proposals include a cap on payment updates over the next several years and introduction of a two-track payment system thereafter. Thus, it is likely that H.R. 574 would have a similar impact on the deficit over the next 10 years.

One significant way in which H.R. 574 differs from H.R. 2810 is the former's greater emphasis on reducing Medicare's reliance on the FFS payment system by making more dramatic cuts to the fee schedule determining physician payment. H.R. 574 provides only a brief description of the "alternative delivery and payment models" identified and tested under Section 1115A of the Social Security Act, but it specifies that such models will be "aimed at improving the coordination, quality and efficiency of health care" and as representing "best practices." This is understood as moving away from the current FFS payment system and toward one that holds physicians responsible for the cost, quality, and outcomes of their work.

Despite an emphasis on efficiency, payment reform experiments have failed to result in significant savings.[4] And allowing providers to choose the payment system in which they participate, as outlined in both H.R. 574 and H.R. 2810, does not create incentives to reduce cost, but rather rewards Medicare providers that already have a lower cost than their peers. The improvements to Medicare payment methods outlined in H.R. 574 are unlikely to result in cost savings and may lead to increases in spending.

The CBO cost estimate is compared to a baseline spending estimate that includes a 24 percent cut to Medicare payment rates in January 2014, a provision of the SGR unlikely ever to take effect (Congress has already delayed the cut until April 2014). Repealing the SGR would have a much smaller effect on the federal deficit were it compared to the annual suspension of mandated cuts to Medicare payment rates, as has been the status-quo for the past decade.

Given the baseline of current law, however, CBO's estimate of the deficit increase resulting from repealing the SGR may be too low. CBO assumes that the resulting fee increase would lead to a "behavioral response" in which physicians reduce the supply of services because of a strong negative income effect.[5] In other words, as fees rise doctors can earn the same amount of money by working less, and they choose to do so.

There are three reasons why this "behavioral offset" is suspect. First, doctors can cut back on their own labor and still increase the supply of services by hiring physician assistants and nurses.[6] (Increased employment of non-physicians also has the potential to reduce costs without compromising quality.) Second, the CBO estimates are best interpreted as a short-run response when the number of physicians is fixed. Over the long run (which is appropriate for a 10-year projection period), the number of physicians may increase in response to an increase in payment rates. Third, an increase in Medicare physician fees would cause physicians to see more Medicare patients and fewer private patients. This adjustment, which we call the "interior" margin, could be large enough to result in an increased supply of services to Medicare, even if the predicted behavioral response did occur on the "exterior" or total margin.

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[3] U.S. Congressional Budget Office, "Medicare's Payment to Physicians: the Budgetary Impact of Alternative Policies Relative to CBO's May 2013 Baseline updated for Final Rule," December 6, 2013, available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/2013%20SGR%20Options%20-%20Final%20Rule.pdf

[4] Lyle Nelson, "Lessons from Medicare's Demonstration Projects on Value-Based Payment," Working Paper 2012-02, U.S. Congressional Budget Office, January, 2012, available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/WP2012-02_Nelson_Medicare_VBP_Demonstrations.pdf

[5] U.S. Congressional Budget Office, "Factors Underlying the Growth in Medicare's Spending for Physicians' Services," June, 2007, available at http://cbo.gov/sites/default/files/cbofiles/ftpdocs/81xx/doc8193/06-06-medicarespending.pdf.

[6] Douglas Brown, Martin Feldstein, and Harvey Lapan, "The Rising Price of Physicians' Services: A Clarification," Review of Economics and Statistics, 56:3 (August, 1974), 396-398.