An estimated $2.3 trillion was spent on health care in the United States in 2007, and the cost of health care continues to grow at an astronomical rate. The $432 billion spent on Medicare in 2007 accounted for more than 3 percent of the U.S. gross domestic product (GDP).

Growing concern about the rate of healthcare spending has forced policymakers and third-party payors to evaluate new cost-control solutions. Many cost-cutting measures being entertained by legislators—including pay for performance, gain sharing, and liability reform—will have a tremendous impact on the traditional delivery of health care.

During the past several years, lawmakers have made several attempts to curtail Medicare's growing budget. Little attention has been made to more sweeping healthcare reform, notably, fixing Medicare's flawed physician reimbursement fee schedule. The financial solvency of the Medicare program is hotly debated and one of the most critical domestic issues facing our nation.

Medicare reimbursement issues

Increased Medicare spending has resulted in complex methods of reimbursing hospitals and physicians. As part of a cost-containment policy for hospital reimbursements, a prospective payment system was established in 1983. This created a set of diagnosis-related groups under which hospitals would be reimbursed based on set fees.

Medicare reimburses physicians based on a fee-for-service model. Beginning in 1992, Medicare implemented a new Physician Fee Schedule (PFS) payment system, based on a resource-based relative value scale (RBRVS). Many third-party payors use the same system to formulate their reimbursement methodologies.

The PFS attempts to relate payments for a service to the actual resources needed to provide that service. A full explanation of how this system works can be found on the AAOS Government Relations Web site (www.aaos.org/dc).

Overall, the formula for the PFS payment schedule responds to changes in volume. If the volume of services increases, the annual update, as determined by the Centers for Medicare and Medicaid Services (CMS) will be lower to maintain a balanced total level of reimbursement. Inversely, if volume decreases, the update will be higher.

Although the problems with the PFS and sustained growth rate (SGR) were anticipated, the first detrimental effects were not experienced until 2002, when physicians received a 5.4 percent reduction due to the conversion factor. Since then, the flaws with the SGR formula have been so pronounced that Congress has been forced to pass annual temporary measures to keep the system from completely falling apart.

In 2003, Congress gave CMS the authority to fix accounting mistakes made during 1998 and 1999. Fixing these errors resulted in a $34 billion infusion into the Medicare physician payment system and prevented another year of reductions in reimbursement, but the legislation did not address the overall problems. Provisions in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) mandated that CMS increase the conversion factor by at least 1.5 percent in both 2004 and 2005, but did not provide for additional funds to pay for this temporary fix. As a result, the money used to fund the increase must be paid back to the Medicare program, with interest, over the next 10 years.

In 2005, Congress again had to take action. The Deficit Reduction Act repealed a 4.4 percent cut that went into effect on January 1, 2006, and froze the conversion factor at the 2005 level. The freeze was paid for by cutting reimbursements for other physician services, mainly imaging services.

Fundamental Flaws

Increased spending on Medicare has focused on policymakers' efforts and numerous legislative initiatives to help control these expenditures, but they do not address the underlying fundamental flaws with the current PFS and SGR. Decreases in reimbursements will likely prompt many physicians, especially specialty physicians, to reconsider their participation in the Medicare program.

The more appropriate action is to restructure the flawed PFS by severing the link between the PFS, SGR, and the GDP. Currently, this link allows CMS to set an “expenditure target” for all physician services, resulting in an unstable payment system, and to defend their steep reductions in physician reimbursement. The AAOS and the Alliance of Specialty Medicine support a formula based on the cost of providing care, such as the Medical Economic Index (MEI).

The SGR is also cumulative (it compares cumulative expenditure targets with cumulative expenditure costs, rather than one year’s expenditure target with that year’s actual costs). The formula requires that excess expenditures be recouped immediately, which makes the system unstable and does not allow yearly changes in volume of services.

In addition, the present system inadequately accounts for costs and savings from new technologies and overall changes in services based on new preventive screening benefits and a greater awareness and demand by consumers. Finally, the target includes Medicare-covered outpatient drugs, even though physicians have little or no control over the costs of these drugs.

Reimbursement rates in 2007 and beyond

If the SGR formula is not fixed, physicians will continue to receive...