Bending the Medicare Cost Curve for Physicians' Services: Lessons Learned from Canada

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In 1997 Congress created the Sustainable Growth Rate (SGR) formula for the payment of physicians under Part B of Medicare. SGR established a target rate of growth for aggregate costs of physician services under Part B, linked to growth in overall GDP. If growth in aggregate Part B costs exceeds the target, the rate at which physicians are paid in the following year is to be reduced by a corresponding amount. In SGR, Congress and the U.S. medical profession jointly confront a policy dilemma with no clear solution. For several years running, Congress has elected to postpone cuts in payment to physicians required under SGR. Absent further Congressional action, in 2013 physicians' fees under Part B of Medicare will be reduced by more than 30 %. The historical roots of SGR suggest that a potential solution lies in shifting to regional expenditure targets—an approach applied successfully in Canada in the 1970s when Canadian Medicare confronted rising physician fees. The commission that created what was to become SGR was aware of the lessons learned in Canada, and recommended that they also be applied to U.S. Medicare.

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In February Congress postponed yet again addressing the question of what to do with Medicare's Sustainable Growth Rate (SGR) policy. Under current SGR legislation, in 2013 payments to physicians for Medicare Part B services must be cut by more than 30 %. A reduction of this magnitude would make Medicare payment rates on a par with Medicaid rates.[1] With relatively few office-based physicians accepting new Medicaid patients,[2] a reduction of this magnitude in Medicare payment rates would likely lead to many physicians no longer accepting Medicare patients—a policy option that does not seem viable.

Under SGR, the aggregate of physicians' charges submitted during a 1-year period are compared to a target amount based on spending in prior years adjusted by inflation in the physicians' practice costs and growth in GDP. If aggregate physician charges exceed the target amount, CMS must reduce the price paid for physician services in the following year by an amount that will recoup the current-year excess.

SGR was passed as part of the Balanced Budget Act of 1997. By 2001 spending on physician services had exceeded the target amount, triggering a 4.8 % reduction in payment rates for 2002. Despite this reduction, aggregate charges in 2002 again exceeded the target, reflecting a disproportionate increase in the volume of services. Rather than permit physicians' fees to fall again, Congress overrode the SGR regulations. Congress has acted every year since 2003 to postpone SGR-required cuts in payment to physicians. Unless Congress acts again, next year's reduction in fees will be more than 30 %.

Why has SGR proved so difficult to adhere to? The answer lies in a lesson learned decades ago, both in the U.S. and in Canada. As reported in 1988, "the Canadian experience provides strong support for the hypothesis that utilization per physician increases to offset control in fees."[3] In 2006 the Congressional Budget Office (CBO) summarized the U.S. experience in nearly identical terms. "Considerable evidence suggests that a reduction in payment rates leads physicians to increase the volume and intensity of services they perform."[4]

Medical care does not fit the classical economic model of supply and demand.[5] The consumer (in this case the patient) relies on the provider (the physician) to define how much and what type of medical care is needed (a situation often referred to as supplier-induced demand). As the one who defines the need for care, a physician might respond to a reduction in the amount paid per patient visit by recommending more frequent visits. In analyzing this phenomenon, the CBO concluded that, "a 1 % reduction in payment rates would lead to a 0.2 % to 0.4 % increase in the volume of services provided." Some surgical specialists respond to a 1 % reduction in payment by increasing services provided by 0.83 %.[6]

Physicians may also respond to lower payment rates by increasing the intensity of the services they provide. Under the Resource Based Relative Value Scale (RBRVS), an office visit coded as "99214" is considered more complex

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than the more commonly used "99213", and is accordingly reimbursed at a rate that is approximately 50 % higher. Between 1992 and 2002, the frequency with which physicians categorized an office visit as code 99214 increased by 51 %. [7] Similarly, over the same time period the frequency of the use of code 99285 for an emergency department visit (reimbursed at a rate that is 48 % higher than the next level of exam) increased by 134 %. This practice of shifting from less intensive to more intensive service codes, with corresponding higher Medicare reimbursement rates, if often referred to as "up-coding."

In both the U.S. and Canada, attempts to control costs by reducing physician fees have typically been met with a corresponding increase in both the volume and the intensity of services. While Canada has been able to deal successfully with this issue, the U.S. has not. Those who laid the groundwork in the U.S. for what evolved into the SGR were aware of the Canadian experience and of its implications for U.S. Medicare.

The U.S. enacted Medicare in 1965, while Canada passed its version of Medicare in 1968. Both systems elected to rely on fee-for-service as the principal method of paying physicians. In the U.S., physicians' fees were initially set on the basis of their "usual, customary, and reasonable" fees charged to other patients. In Canada, by contrast, the initial payment of physicians was based on a fee schedule established by the provincial medical association, with all physicians within the province charging essentially the same fee.[8]

Within a few years of enactment, both countries were experiencing rapid increases in aggregate physician charges, leading to various attempts to freeze or otherwise cap physicians' fees. Each attempt was met with corresponding increases in the volume and intensity of physicians' services. Between 1965 and 1971, per capita expenditures for physicians' services in Canada increased by 109 %. In the comparable period following the enactment of U.S. Medicare, expenditures for physicians' services increased 87 %. By 1971, expenditure for physicians' services accounted for approximately 1.3 % of GDP in Canada, and 1.4 % of GDP in the U.S.[3]

As shown in the Figure 1, between 1971 and 1977, individual Canadian provinces enacted various efforts to constrain physicians' fees, usually involving negotiations between the provincial health plan and the provincial medical association in setting the fee schedule. Then, in 1977, the Canadian federal government took action that would eventually differentiate the Canadian experience from that in the U.S. The federal government switched from an open-ended reimbursement formula to what was essentially a block grant formula. Each year the federal government would pay a province an amount based on the previous year's expenditure, adjusted for overall inflation and for the growth in GDP. Any increase in the costs of operating the provincial health plan that exceeded the growth in real GDP would have to be born 100 % by the province.

Between 1977 and 1984, the provinces enacted policies linking increases in physicians' fees to growth in real GDP. When physicians responded to reduced fees with an increase in the volume of services, fees for the following year were correspondingly reduced so as to stay with the GDP growth curve. While each province established its own mechanism to cap physicians' fees, the outcome across provinces was generally the same. By 1985, physicians' fees in Canada remained at their 1971 level of 1.3 % of GDP, while physicians' fees in the U.S. had increased from 1.4 % of GDP to 2.1 % of GDP.[3]

Within a few years, Canadian physicians had largely accommodated themselves to annual negotiations between

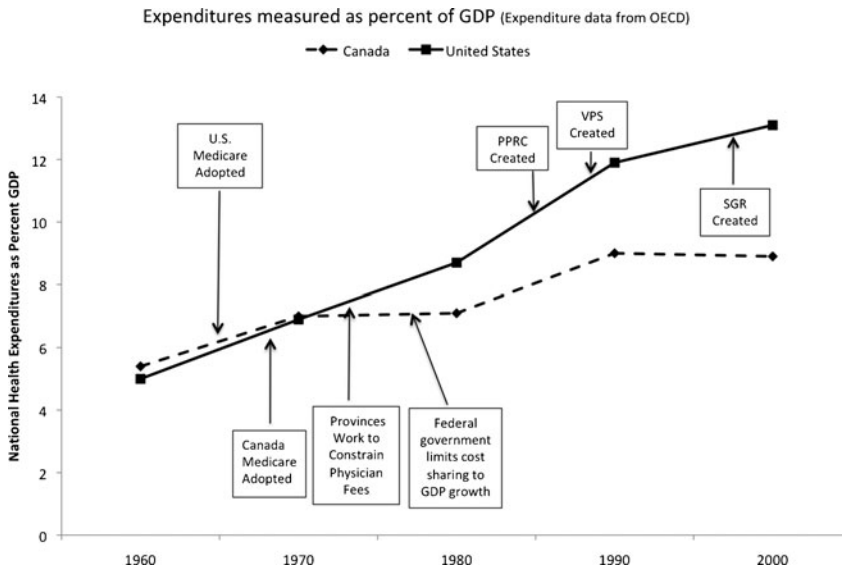

Figure 1. Actions taken to control health care expenditures in Canada and the United States, 1960–2000].

the provincial government and the provincial medical association to set fees for the following year, based largely on growth in real GDP.[9] By the late 1980s, a central policy principle had been established in Canada: "Fee schedules have been able to contain costs whenever the provincial governments could exercise the political will to respond to accelerated utilization with aggressive fee reductions, utilization controls, or both."[10]

In an attempt to constrain the rapidly increasing cost of physician services under U.S. Medicare, in 1986 Congress created the Physician Payment Review Commission (PPRC) and charged it with advising Congress on possible reforms to physician payment under Medicare. In its first annual report to Congress, the PPRC identified one of the central issues it confronted: "A payment system based on a fee schedule needs to include mechanisms to control the provision of services…A cap on expenditures could reduce the fee paid for each service when total expenditures in an area exceeded a target."[11]

PPRC members visited several Canadian provinces to learn more about the recent Canadian experience in establishing and enforcing caps on payments for physician services.[12] In 1989, PPRC reported to Congress its recommendations to establish the RBRVS as a basis for paying physicians under Medicare. Under RBRVS, each of the various services and procedures physicians provide is allocated a specified level of resources (time, training, materials, etc.), measured in what are described as Relative Value Units (RVUs). A service allocated 2 RVUs requires twice the level of resources as a service allocated 1 RVU. On an annual basis, Medicare simply defines the "conversion factor"—the rate at which it will reimburse a single RVU. Other services are then reimbursed at that reimbursement rate multiplied by the number of RVUs allocated to the service.

As part of its 1989 recommendation, PPRC was explicit in constraining payments to physicians by tying the conversion factor to the overall level of spending.

"[A]nnual increases in the conversion factor for the Medicare Fee Schedule are based on how increases in spending per enrollee compare to a target rate of increase… The expenditure target should initially apply to all physicians' services nationally. The policy is expected to evolve, leading to incorporation of a broader range of services and to separate targets for regions and/or categories of physicians' services."[13]

The PPRC Report reflected the lessons learned in Canada—that the global cap on fees worked best when applied on a regional basis. The Report was explicit in recommending regional, rather than national, expenditure targets as the optimal approach for the new Medicare fee schedule in the U.S.

"The advantage of a smaller geographic area is that state and local physician organizations could play a larger role in attempting to affect practice through education and peer review…With regional targets, physicians might feel that they could work through their local organizations to meet state or metropolitan targets, while national targets would encompass too many aspects of care beyond their control."[13]

A 1986 Canadian study referenced by PPRC staff underscored the importance of adopting a regional approach to prorating physicians' fees. "The larger the group of physicians over which prorating takes place, the more likely each physician is to respond simply by increasing his/her billings without taking account of the effects of this action on other practitioners…The practitioners in each community, however, will have a direct and identifiable financial stake in the pattern of practice in that community."[14]

In recommending that U.S. Medicare adopt a regional approach, the 1989 PPRC Report underscored the key role physicians' organizations would play in carrying out expenditure targets.

"Expenditure targets…are intended to stimulate a collective response by the medical community. Through its organizations and leadership, the medical profession can influence the clinical decisions made by individual physicians through educational programs, development and dissemination of practice guidelines, peer pressure, and by working with Medicare to strengthen and improve utilization and quality review."[13]

Why would physicians in New York or California change their practice pattern in response to high rates of Medicare Part B utilization coming out of McAllen, Texas or Miami? They wouldn't. On the other hand, if physicians in a specific state or region knew that their Medicare reimbursement would be affected by the actions of other physicians in their professional community, they could work with local or regional professional organizations "to strengthen and improve utilization and quality review."

In its final report, the PPRC recommended creation of an "expenditure target formula" based on a combined measure of increases in physicians' costs of practice, growth in the Medicare enrollee population, and growth in the GDP. Growth in the aggregate cost of physicians' services that exceeded the target would trigger reduced reimbursement rates in the following year, thus maintaining per-enrollee costs. Congress acted in 1989 to adopt the recommendations of the PPRC, establishing the RBRVS for determining physician payment and creating a "volume performance standard" (VPS) to monitor and adjust physicians' fees.[15] The formula used to calculate the VPS resulted in wide swings in payment rates to physicians, however. As described by the Director of the CBO, "That volatility led Congress and the President to modify the VPS in the Balanced Budget Act of 1997, replacing it with the sustainable growth rate mechanism in place today."[16] SGR was to be applied on a national basis only, without regard to

regional variations in the volume or intensity of physician services.

Beginning in the 1960s, the U.S. and in Canada had engaged in parallel struggles to contain the cost of physician services under their respective Medicare programs. The relative success of several Canadian provinces in constraining those fees provide an important lesson for Medicare payment policy in the U.S. The lessons learned in Canada suggest that the SGR will not work in the U.S. until two fundamental changes take place. First, physicians, through their professional associations, must accept responsibility for adhering to established targets for overall Medicare spending on physicians' services. Second, for physicians to accept responsibility for the societal consequences of their clinical decisions, they must have a sense that their local colleagues share this sense of responsibility. This type of professional cohesiveness can realistically be attained only on a regional basis.

Canada has established a national single-payer system administered by provincial governments, while the U.S. has opted for a mixed public/private system administered by the federal government. In Canada, payment policies set and enforced by the provincial government leave physicians little choice but to adhere collectively to caps on overall expenditures. By contrast, many in the U.S. are looking to an expanded role for market-based insurers as an alternative means of "bending" the Medicare cost curve.[17] The answer to the question of whether lessons learned in Canada can aid in finding a solution to the current Medicare cost conundrum in the U.S. depends to a large extent on whether U.S. physicians perceive themselves as members of a profession that owes a collective duty to sustaining a viable health care system that balances the needs of patients with the economic concerns of physicians.

The very origins of the organized medical profession in both countries depended on support from government through the establishment of laws pertaining to licensure and certification. The approach adopted by both provincial and federal governments in Canada is that the profession in return has the collective responsibility to collaborate with government to assure that the system remains economically sustainable.[18] By moving to a regional system of expenditure caps, as Canada did several decades ago, U.S. physicians have the potential of acknowledging and acting on that responsibility. Whether we can regain that sense of collective responsibility will be a principal determinant of the ultimate direction Medicare payment reform will take.

Economic constraints on physicians' clinical decisions are inevitable. The question remaining is where the constraints will come from, and how they will be applied. In 1989, Arnold Relman, Editor of *The New England Journal of Medicine*, described the dilemma physicians face in an editorial titled "American Medicine at the Crossroads: Signs from Canada." Relman argued that, eventually, physicians in the U.S. would have to accept some form of economic constraint on their practice. The question yet to be answered was whether those constraints would be applied through the specific regulation of clinical decision making or through autonomous professional control under global expenditure targets. Relman suggested that, "When that time comes — and it may be sooner than we think—doctors in this country may want to take another look at the Canadian experience."[19]

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