Editorial

»Robert L. Barbieri, MD Editor in Chief

Medicare and Medicaid are on the brink of insolvency, and you're not just a bystander

The federal government might resuscitate these two popular benefit programs by siphoning revenue from private medical practices

Medicare and Medicaid are two of the most popular government benefit programs. They secure the health of the poor, the disabled, and the retired by encouraging physicians to provide easy access to their practice for those who are covered.

Medicare and Medicaid are also two of the most expensive government programs ever devised, and **they are drifting toward insolvency. That could trap your practice in a vortex of ever-decreasing practice revenue and ever-increasing practice costs.** Here's how such a scenario might unfold as 2011 draws to a close and powerful forces and events in politics, government, and business promise to intersect in the new year.

Method and math behind Medicare and Medicaid

Medicare. The widely held belief is that Medicare is supported by a trust fund built by contributions from payroll taxes. But that's wrong: Medicare is part of what is known as the unified federal budget, and taxes collected for the program are not physically set aside in some sort of lock box. Rather, those tax receipts are used for the general expenses of the federal government. That's correct: **No real assets are tucked away that could be used to pay future Medicare obligations.**

When the federal government borrows money from the stream of Medicare tax revenue, it issues an IOU to repay that loan. (Many economists consider it fuzzy accounting to borrow money from yourself, spend it, and cover the debt by issuing yourself an IOU.)

Until recently, Medicare taxes more than covered the costs of Medicare services. That allowed the government to use the surplus to pay for other expenses, such as defense and education. But (outgoing) Medicare costs now exceed (incoming) Medicare taxes, resulting in a net budget deficit and requiring either **1)** contributions to the program from general tax revenues or **2)** borrowing, which adds to the mounting federal deficit. Medicare administrators have estimated that the program's Part B (See "Medicare comprises 4 related health programs—its 'Parts'", page 10), which pays for physician visits and is financed by both patient premiums and general tax revenues, has a **$36.4 trillion unfunded liability** (compare the total size of the US economy: approximately $15 trillion a year).

Medicaid. This program—the joint responsibility of federal and state governments—is funded by general tax revenues. As the finances of the federal and various state governments deteriorate, **the stability of Medicaid is also in jeopardy.** Many states are attempting to reduce their Medicaid expenses by restricting enrollment and using managed care programs to control the volume of services. Ominously, Medicaid programs are imposing across-the-board cuts in reimbursement to physicians and hospitals.

Precarious financial footing. As Medicare and Medicaid teeter, the two programs also prepare to add millions of new members over the next few years:

- **Medicare** enrollment will increase significantly as more and more Baby Boomers reach 65 years of age. Enrollment has also grown because Americans are living longer.
- **Medicaid** enrollment will increase by 10 to 20 million over the next few years because national healthcare legislation facilitates enrollment of uninsured adults into this program.

If both programs are on the brink of insolvency now, who is going to pay the expenses of millions of new enrollees?

One solution? Many government leaders believe that **your practice revenue is a piggy bank that will help finance these two popular programs.** So how might these leaders in

REFRESHER

Medicare comprises 4 related health programs—its "Parts"

Part A
Pays for hospital services. Supported by the Medicare portion of the payroll tax—currently, 2.9% on all earned income. Employee and employer split the cost; self-employed persons pay the full 2.9%.

In 2013, the Medicare tax rate will rise 0.9% for persons earning more than $200,000 annually. In addition, a new Medicare tax of 3.8% will be assessed on all investment income of persons earning more than $200,000. Note that the Medicare tax has never been assessed on investment income.

If savings on the cost of hospital care that will be implemented as part of national health insurance are realized, this portion of the Medicare program is, financially, relatively stable.

Part B
Pays for physicians' and other health-care professionals' services. Financed by beneficiary premiums (25%) and general tax revenues (75%). Beneficiary premiums are, currently, based on income: Wealthier people pay premiums at higher rates.

The administration of home health services—a rapidly growing component of Medicare services—have been transferred from Part A to Part B, a move that has undermined the financial stability of Part B.

Part B is on the brink of financial insolvency, unless: benefits are reduced; long-planned cuts to physician payments are implemented; or enhanced revenue sources are identified—or any combination of these actions.

Part C
Refers to so-called Medicare Advantage plans, which combine Part A and Part B in a Medicare-approved private HMO or PPO product.

Part D
Pays for prescription drug coverage.

Congress and the Administration tap into the revenue of your practice?

1 Government can exert monopsony power

In the study of economics, monopsony describes a market in which one dominant buyer (in this case, the federal government) interacts with many smaller suppliers (physicians and physician groups). As the principal purchaser of goods, the monopsony power dictates terms to suppliers.

A single-payer, universal health-care system in which government is the only purchaser of health services is a good example of monopsony.

Today, federal and state governments collectively purchase approximately 50% of all health services. This effectively gives them monopsony power to dictate to physicians how health services are reimbursed. Federal and state involvement in health care is likely to grow, further consolidating government monopsony power over physicians.

2 Government can put the squeeze on Medicare payments to physicians

Medicare payments to most physicians are currently provided on a fee-for-service basis. Almost all your services are, as you know, assigned a relative value unit (RVU); Medicare then assigns a dollar value to an RVU, with a small adjustment for the local cost of practicing. Total physician revenue paid by Medicare is therefore calculated as:

sum of all RVUs provided × assigned dollars/RVU.

The Center for Medicare and Medicaid Services (CMS) has the power to reduce **1)** the dollars paid for an RVU and **2)** the assigned RVUs for any given service provided. An example of this power: CMS recently proposed **reducing the RVUs for a global delivery by 11%**—a move that would lead to a direct reduction in physician revenue for a delivery.

More worrisome is the impending (January 1) implementation of a 30% reduction in dollars/RVU mandated by the Balanced Budget Act of 1997. Congress could block implementation of this revenue reduction, but that would add about $360 billion to the federal deficit over 10 years. And it would be paradoxical (and politically explosive) for the newly created Congressional debt super-committee to propose an increase in the federal deficit as its first act....

Many leaders in Congress recognize that Medicare (and Medicaid) costs must be reduced. But they are loath to fan the anger of their constituents by proposing service reductions to Medicare beneficiaries, who come out to vote in large numbers. That's why some of those leaders have advocated that **all reductions in the Medicare budget be borne by you and me, the physician-providers, and by hospitals and nursing homes.** Effectively, leaders

in Congress view government payments to your practice as a revenue stream that could be reduced to help cover the deficits in the Federal budget.

3 Government can reduce the already penurious level of Medicaid compensation

Historically, the Medicaid program compensates physicians at a dollar per RVU rate far below what is paid for Medicare services. Medicaid serves mostly poor patients, who have little political power and no meaningful resources to finance their health care. Serving Medicaid patients amounts to pro bono work by physicians, whose expectation is that they will receive markedly reduced reimbursement for each service they provide. (This is not necessarily an appalling notion: Providing free or reduced-cost services to the poor is a centuries-old tradition for physicians.)

Regardless of how you view pro bono care of the poor, economic analysis suggests that, even under the best circumstances, Medicaid payments are unlikely to ever be a stable source of revenue that contributes significantly to the financial survival of a medical practice. Yet, when states face recession-associated reductions in tax revenue, many have, abruptly, reduced compensation under Medicaid for care provided by physicians, hospitals, and nursing homes or temporarily suspended Medicaid payments altogether.

In response to such arbitrary actions, providers have sued some states to stop capricious pricing of Medicaid services. The US Supreme Court has agreed to hear such a case to determine if states can legally set the rate for Medicaid payments far below the cost of providing care.

ILLUSTRATION: DAVE CUTLER/STOCK ILLUSTRATION SOURCE

4 Government can expect commercial insurers to play follow-the-leader

For most physicians in private practice, payments from commercial insurers are the stable source of revenue that protects that practice from insolvency. Because most commercial insurers aren't of sufficient size to exert full monopsony power, physicians have often been able to negotiate rates with these companies that are higher than the reimbursement rates set by Medicare.

There is now growing consolidation in the insurance industry, however, and insurers are prone to adopt the decisions of Medicare administrators—that is, they are using the monopsony power of the government as a proxy to help control physicians and hospitals, who are their principal suppliers.

If Medicare reduces the RVU value assigned to individual services (e.g., the proposed 11% decrease in RVUs for global delivery services), for example, or reduces dollars paid per RVU (e.g., the 30% reduction that I already noted scheduled for January 1), commercial insurers are likely to follow suit when they renegotiate contracts with physician and hospital suppliers. It's certainly possible, then, that upcoming government-initiated reductions in reimbursement for physicians will

Instant Quiz

Who was the first person to be enrolled in Medicare? The second?

Find the answers on page 16.

trigger industry-wide deflation of reimbursement.

What's the near-term outlook for private medical practices?

Given its monopsony power in health care and its financial instability, the likelihood seems high that **the federal government will act to reduce the revenue stream to physicians, hospitals, and nursing homes.** And, although practice revenue will likely decline, the government has shown little interest in helping physicians reduce the costs of their practice.

The government could, for example, reduce practice costs through tort reform or by simplifying complex administrative rules and procedures. Both actions would likely provide the added benefit of improving patient care.

Sink or swarm? For practices that are treading water, a government-mandated reduction in revenue may force their owners to close shop, retire early, or join a large group practice. And, if the government boldly exerts monopsony power, it's possible that independent physicians will join together in large group practices—and that might catalyze employed physicians to form professional unions. Physician unions are common in, for example, Germany and Canada, where the government exerts monopsony power in health care; there, physician strikes or work slowdowns occur about once a decade.

Stay tuned! I welcome your comments on these potential threats to the survival of private medical practice, to obg@qhc.com.

OBG@QHC.COM