

Planned Medicare Cuts Weigh on Primary Care

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While presidential candidates are beating each other up about their plans for the uninsured, they've taken their eye off another big issue. Access to primary care for millions of people enrolled in Medicare is in peril.

As each new year approaches, doctors across the country brace for cuts in payments from Medicare. Unless there's a reprieve soon, Medicare will reduce payments to doctors by an average of 10.1% starting Jan. 1. Last year a planned reduction of 5% was averted by Congress at the last minute and payments stayed about flat.

Another deal remains possible. But the constant threat of decreases and the absence of increases in recent years are leading doctors to re-think their commitment to caring for Medicare patients. The question is becoming acute for primary care doctors, who are faring worse than those in other specialties.

To see why, it's worth a quick look to see how Medicare calculates how much to pay a doctor for care. There's a complex formula, but one of the keys is something called a work relative value unit that Medicare assigns to doctors' activities based on their specialties. An hour of brain surgery is valued more highly than an hour of general medical care.

Where a doctor practices also influences the payment calculation. Rural health clinics like mine operate under a special government program and will likely get a small cost of living adjustment next year.

In the end, Medicare multiplies a total relative value unit, factoring in various adjustments, by a payment benchmark to come up with fees for physician services. (For more, see [this summary](#) from the American Medical Association.)

The formula means that there are two ways for doctors to gain or lose under Medicare. The benchmark can be adjusted up or down, affecting all doctors. And the modifiers assigned to each specialty can be increased or decreased. Adjustment of the financial weight given to specialties is generally a zero-sum game and that pits one group of doctors against another in the lobbying wars.

Family medicine has been a loser, with its modifier decreasing since 2001. My medical school classmates who opted for anesthesiology are in line for a 4% increase next year. Coupling the lower payment factor for family medicine with the planned 10.1% drop in the benchmark for Medicare equals a big hit to primary care.

The Medicare crunch has been a big topic of conversation in an online discussion group on practice management run by the American Academy of Family Physicians. I'm a member and have found the chatter a little depressing.

As you might imagine, some doctors predict more grumbling and then eventual acceptance of what would amount to a salary cut for seeing Medicare patients.

Some expect to see more Medicare patients to make up for cuts with higher volume. Dr. Shane Avery, a solo practitioner in Scottsburg, Ind., will ask patients to come to the office for everything, no matter how small. Medicare doesn't pay enough to cover his overhead for the range of services he provides outside of an office visit, such as phone consultations.

Dr. Kathy Saradarian of Branchville, N.J., predicts Medicare cuts will prompt doctors to see patients more often but spend less time during each visit. But even that adjustment may not be enough. In her area of New Jersey, insurance payments are so low that Medicare is her best payer. Any cuts will come right off her bottom line. "They think we can make up the losses in other ways, but we can't," she says. "It is disheartening."

Others are considering dropping out of Medicare altogether. Dr. Marie Steinmetz, of Alexandria, Va., stopped taking Medicare six years ago because the payments didn't cover her expenses. Her practice offers traditional medical care with complementary and alternative medicine that insurance generally doesn't pay for anyway.

A family doctor in rural California named Deborah Sutcliffe stopped taking new Medicare patients two years ago. Now she's thinking about requiring her remaining Medicare patients to pay her directly rather than taking her fee via Medicare. If she goes this route, she's allowed to charge a slightly higher price. Medicare sends partial reimbursement for the office visit to the patient, and the patient pays the difference. This approach usually results in more overhead for a practice, but the total collections for the same sorts of visits can be 15% higher.

Elizabeth Pector, a family practitioner in Naperville, Ill., worries most about the effect a Medicare cut could have on other insurers. Many tie their reimbursement to Medicare. If the private sector rates drop 10%, too, her practice could be in big trouble. She worries about the health and options for our seniors, but finds herself worrying more urgently about the health of her practice.

While everyone's talking about how to expand health care for the uninsured, I think it's time to fix the Medicare system that's leading many doctors who tend to the basic health-care needs of the elderly to reconsider the proposition.