Medicare 'reform' will hit the elderly

by Steve Parsons

On May 31, U.S. Medicare officials announced the most sweeping changes in reimbursements for physicians since the inception of the program in 1965, and the changes will be a disaster for the 34 million elderly and disabled now covered by the program.

The new fee schedule, which will go into effect Jan. 1, 1992, will standardize reimbursements throughout the country for more than 4,000 services, thus abolishing the traditional method of reimbursing "usual and customary" fees, which have increased far beyond the average rate of inflation and have been much higher for urban areas. The new schedule is touted as key to staunching the doctor drain from rural to urban areas, by reducing the monetary advantage that urban physicians have had over rural practitioners—especially if private insurers follow the Medicare schedule, which they undoubtedly will do.

Specialized health care suffers

The new schedule is also supposedly designed to lessen the imbalance between "excessive" fees for specialist practices and procedures—including ophthalmology, anesthesiology, diagnostic services, and surgery—and relatively lower fees for internists and family and general practitioners engaged in more "preventive" medicine.

The revised fees, however, permit only a modest and totally inadequate increase for general practitioners and internists, while slashing reimbursements for more sophisticated medical practices. By 1996, reimbursements for general hospital and office visits will increase 26-27%—which amount to perhaps 15% more than would have been paid out under current fee policy. This doesn't come close to offsetting nearly 40% in cuts by 1996 in virtually all the more specialized areas.

For example, Medicare would pay physicians who performed coronary bypass surgery only $1,925 in 1996, compared to $3,181 this year; cataract surgery would only get $832, against $1,342 this year; radiation therapy would receive $99, against $162. Although fees in future years will be increased for an inflation factor, Congress has set that factor at less than 4%, meaning that the 40% cuts will actually amount to well over 50% by 1996.

That means an enormous increase in the number of doctors who will refuse to treat Medicare patients, or reduce treatment, unless these patients pay the difference out of their own pockets. When the private insurance companies follow suit, countless other patients—and doctors—will wind up in the same boat.

Furthermore, as the American Medical Association points out, these reductions signal that the Bush administration is "nullifying payment gains for many rural and primary-care services," contrary to the intent of Congress. In fact, according to Dr. Robert Graham, executive vice president of the American Academy of Family Physicians, "Some family physicians could lose money on some services." The only major difference in urban and rural physician costs that Medicare will now cover is higher "office costs," the largest component of which is higher office rents. This means *de facto* Medicare subsidies for the collapsing real estate and banks' mortgage debt.

Disguised budget cuts

Even though, under the revised fees, Medicare payouts to physicians will rise from this year's $32 billion to $50 billion in 1996, that is $3 billion less than projected under the current system. This $3 billion "savings" is actually a cutback, charges Dr. Graham, "a budget-reduction strategy, not the congressional intent of physician payment reform," which mandated a more equitable distribution of Medicare payments across the professions, while fostering higher remuneration for "primary care" and rural physicians. That $3 billion is what the AMA and other physicians' organizations believe should go for family physicians. This would have given them a 30% real increase instead of the 15% now proposed, and resulted in better preventive care.

The government responded that the savings was just by chance, due to "technical factors" in setting the fees, with no intent to cut the budget. That's pure hogwash. In fact, the fee revisions reflect the cost-accounting numerology of the gnomes at Medicare's Health Care Financing Administration (HCFA). With total disregard for any of the intangibles in competent medical treatment, these bureaucrats set fee "values" on 4,000 medical treatments, assigning values from 1 to more than 110. These numbers are based on "studies comparing the time, effort, and stress it takes to perform" different medical services, reports the *Washington Post*—but actually reflect the budgeting decision "that surgery and other complex procedures have heretofore been too highly valued relative to consultations and office visits."

That's not all. HCFA then chose a magic number—$26.87—to be the "conversion factor." This is the base number that is then multiplied by the numerical "values" of the various procedures, to get the Medicare reimbursement fees. By simply reducing this magic number, and assigning lower "values" to procedures, the entire fee schedule can be cut.

These are the "technical factors" that just happened to result in a $3 billion "saving," and will undoubtedly be used to slash more and more from Medicare, and all health insurance, in the future.