

Health Care Reform and the Retina Subspecialty

BY WILLIAM L. RICH III, MD, FACS, AAO MEDICAL DIRECTOR OF HEALTH POLICY

In this issue of Retina Today, we are sharing the Editor's page with our esteemed colleague in ophthalmology and advocate in Washington, William L. Rich III, MD, FACS. Dr. Rich was invited to provide our readership with an update on the health care reform initiative being debated in the US House and Senate. The potential changes to our health care system are significant and may include addressing the uninsured and underinsured and how physicians are paid for the care that we provide; the shape of the final package is still undetermined.

Dr. Rich provides us with an overview of the challenges the government faces, some of the proposed changes, and the impact that these changes will have on our profession. It behooves us to remain abreast of the developments that are currently taking shape in Washington, as they will ultimately affect the quality of care that we are able to provide our patients.

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There is a general bipartisan assumption that the United States will enact health care reform in 2009. There are many factors influencing the sense of crisis and need for

reform. In 2006, health care costs in the United States equaled \$2.2 trillion and it is estimated that the 16% of the gross domestic product (GDP) spent on health care will increase to 20% by 2017.

These high health costs make it difficult, if not impossible, for American business to compete globally. For example, in 2006, fewer than 5% of insurance plans were "classic" indemnity plans, with higher out-of-pocket cost—approximately 14% of total costs of commercial plans are paid out-of-pocket by patients. And in 2005, the average family premium was \$11,941—an increase of 85% over 10 years.

How is government-sponsored health care faring? Not well. It is estimated that Medicare Part A will go bankrupt in 2019. Meanwhile, Part B costs are exploding, and are being

paid for with current tax revenues under funding pressure during a recession. Medicare Part B premiums have doubled since 2001.



Other factors that influence the sense of crisis include the statistic that currently there are 46 million uninsured (mostly working) people living in the United States. Despite the explosive growth in health care spending, Americans receive only 55% of recommended care.

Clearly, we are unable to cover patients' health care needs under the current system, and there is universal agreement that no attempt to cover the uninsured is possible without payment reform. The bipartisan assessment of

Congress is that the status quo of high costs, less-than-optimal quality, and low value with a large number of uninsured is unsustainable. Payment reform, however, will entail slowing the growth of fast growing services before value-based purchasing and universal coverage can be implemented.

THE GOVERNMENT RESPONSE

For the reasons listed above, we now find ourselves at a propitious time for legislation. With a worldwide recession, exploding business health care costs, and more people losing health care coverage every day, there is widespread public support for comprehensive health care reform. To show it means business, the administration backed up President Obama's campaign words with more than \$1 trillion budgeted to cover the uninsured. Given the current political climate, the resolve of a Democratic-controlled White House and Congress, and the staggering sums of money already pledged, the U.S. House and Senate have begun drafting legislation.

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This spring and early summer, the House and Senate drafted bills to cover the uninsured. The estimated 10-year cost of covering the uninsured, however, is \$1.2 trillion: real money, even in Washington these days. Before passage, Congress must find funding sources. Under consideration are new mechanisms, including taxing individual health care benefits when the value exceeds a given threshold; imposing an employer fee for companies who do not provide meaningful health benefits; mandating competitive Medicare HMO bidding; ensuring more competition in Medicare Part D pharmacy plans; creating a new public plan to compete with commercial plans to cover those without insurance; payment reform for hospitals, physicians, devices, and home health; and new "sin" taxes on fatty foods and enriched high caloric drinks. One can also expect the politically expedient possibility of raising taxes on the wealthiest.

MEDICARE PHYSICIAN PAYMENTS

Currently, Medicare physician payments are under tremendous pressure due to a budget constraint imposed by Congress in 1997: the sustainable growth rate (SGR). The assumption is that medical service growth per beneficiary should not exceed the growth in the GDP. Medical services always do. The service categories with the highest volume growth are high-end imaging, drugs administered in the office, and office-based testing.

Without Congressional intervention, physicians face a

22% cut in fees January 1, 2010. The cost to eliminate the onerous SGR is \$339 billion, but President Obama has removed drugs from the SGR during rule-making and budgeted \$339 to eliminate SGR in his health care reform proposal. President Obama's decision to take drugs out of the SGR and eliminate the looming cuts reflects his commitment to strengthening Medicare fee for service (FFS), whereas the previous Republican administration refused to enact these changes. This refusal was largely because of its desire to make FFS less attractive to physicians and patients and hopefully drive them into Medicare HMOs, which historically pay physicians 75% of FFS. Other commitments to ensure a vibrant Medicare FFS program are reflected in the Obama administration's commitment to increasing payment to primary care by correcting excess imaging payments. The proposed Medicare payment regulations due to be implemented in 2010 provide for 10% cuts to radiology, interventional radiology, and radiation therapy. Additionally, the dollars from elimination of consultation codes are shifted to office-based evaluation and management codes, further enhancing primary care payments. Any decreases in revenue for retina specialists from elimination of consultations is more than offset by the shift in payments for practice expenses and professional liability from imaging specialties to surgeons and primary care. Ophthalmologists are slated for an 11% increase in payments on January 1, 2010.

NEW METRICS FOR EVALUATING THE VALUE OF SERVICES

The bad news is that these favorable payment policies assume that physicians will change the ways they practice. The Congressional Budget Office estimates that 30% of services in this country are not medically necessary. Currently, physicians are rewarded for the volume of services they provide irrespective of outcomes or value of the service. No longer will we be paid on the basis of the volume of services we provide; rather, outcome and efficiency metrics will be the norm.

Even with these value-based reimbursement schemes, there will be constraints on the amount of money allocated to physician payments. Physicians will be under great scrutiny to justify the medical necessity of patient visits, tests, and procedures. Payers have developed a large number of screens to identify potentially misvalued or unnecessary services. The most common is the use of volume growth screens. Economists assume that if a service is growing faster than the overall rate of volume growth of other codes, the patient population has changed, the payment is too high, and increased use leads to greater productivity. Thus, the final assumption

is that the price should be lowered.

When a service is identified as having unusually high growth, assuming the population of patients has not changed, several mechanisms are evaluated to curtail payment. First, scrutiny is given to the service provided to make sure a new technology is not being inappropriately coded using a current procedural terminology (CPT) code. Many manufacturers attempt this strategy and encourage ophthalmologists to code inappropriately. This practice places the physician at legal risk and endangers the value of the underlying service. Payers have recently mandated that either a technology assessment be performed before payment is made or that the underlying code value be lowered. "Creative coding" for personal financial gain or to aid industry leads to lower payments for all.

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For example, in the event that new diagnostic technology enables physicians to perform several tests at the same sitting, new coverage decisions will then ensue, disallowing provision of more than one service. Alternatively, the services will be bundled together, resulting in a significantly lower payment. Codes that are used at an increasingly frequent rate will be evaluated to see if a new technology or software decreases physician work or expenses. The end result is a marked decrease in the fee.

THE COST OF CHANGE

In summary, ophthalmologists are going to experience positive Medicare reimbursement payments in 2011 of at least 11% if the proposed payment rule is implemented. President Obama will continue to enhance FFS Medicare. Any health care reform to cover the uninsured, however, will come with mandated changes in the underlying methods of physician payment. Ophthalmologists will be rewarded on the basis of the value of services provided. Savings from current payment valuations, however, must occur up front to help finance these new payment methodologies. ■

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