Current Perspective

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How Much Is Not Enough? Part One

As we gear up for the 2020 elections, health care reform is considered the most or one of the most critical issues. In one poll, 88% of respondents said that lowering the cost of health care was "extremely important." And 92% in the same survey said that lowering drug costs was "extremely important." Of note, 53% reported that health care costs affect their household "a lot."

The biggest drivers for lowering costs—based on their percentage of the health care expenditure dollar and/or their rate of rise and/or their vulnerability—appear in most surveys to be drug costs, hospitals, and administrative overhead.

However, physician payment is considered by many economists and policymakers to be a legitimate target as well. Many hold to the aphorism that while physician (and other "provider") fees account for only about 20% of health care costs, they control much of the other 80% by ordering the laboratory tests and imaging, recommending the procedures, and dictating the site of service. (We all know that's not entirely true, but we'll leave it for another column.)

Within the physician community, payment is wielded as a blunt policy axe, approached on a zero-sum basis, shifting reimbursement from specialists to primary care physicians such that over the past decade most primary care physicians have seen Medicare payments increase 15%-20% while many specialty services have decreased by an even greater amount. Although I would argue that primary care has been historically underpaid, the zero-sum approach within aggregate physician payment fails the "fairness" test.

It is true that nearly all other developed countries pay physicians less than in the United States. One study noted that the mean purchasing power equivalent remuneration for both generalists and specialists was significantly higher in the United States. (The same was also true for other health care professionals and is true for many professions.)

At the same time, American physicians can make a very cogent argument that while aggregate compensation has increased in recent decades, it has not done so in real cost-of-living dollars. Data from the Medicare Trustees' Reports and U.S. Bureau of Labor Statistics reveal that between 2001 and 2017 Medicare inpatient hospital updates increased 50%, whereas physicians' increased only 6%. During the same period of time, the Medicare Economic Index (a rough equivalent for practice costs) increased 30%. On an inflation-adjusted basis, physician payments decreased 19% over those 18 years—and more for cost-heavy specialties (like ophthalmology). Surgical procedures have been repeatedly cut to benefit office visits. As an example, between 1992 and 2019, the work value for cataract surgery (CPT 66984) has decreased 18%—while the work value for a Level 4 established patient office visit (CPT 99214) has increased 61%.

In fact, an oft-quoted study targeted this disparity when it concluded that reduction of health care spending "should be primarily focused on addressing growth in hospital rather than physician prices."

Most of us know that our practices have economically weathered this situation by increasing patient volumes, finding business efficiencies, and developing other revenue sources. Ophthalmologists generally make comfortable incomes. But many recognize that the MACRA payment schedule calls for 0% fee updates between 2020 and 2025—even as physician practice costs will continue to escalate.

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At what point does this become unsustainable? Are we there already? And what will happen when it does? Does patient access to unique ophthalmic services worsen? Does it stress professional behavior? Does it impact the very existence of small practices? Tragically, the patient will also pay the price.

In my next column I'll address where this may lead us, what you can do, and how the Academy and other organizations can potentially impact the course of future events.

SOURCES:
Blendon RJ et al. *N Engl J Med.* 2019:DOI:10.1056/NEJM p1905710.
Cooper Z et al. *Health Affairs.* 2019;38:184-189.
Papanicolas I et al. *JAMA.* 2018;319:1024-1039.