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FROM THE DESK OF THE PRESIDENT

The Medicare Dilemma

The current pressures of practicing medicine, such as cost, quality of care, pay-for performance (P4P) and electronic medical records (EMR), have physicians scrambling to keep their practices viable. Then there is the additional pressure of overall diminishing reimbursements. Since the early 1990s there has been a steady decline of Medicare fees with no end in sight. In fact, the 2003 reimbursements were 13% below 1992 and a 5% cut for 2007 was narrowly averted, resulting in a 0% change for 2007, but a possible 10% cut looms in 2008. Commercial insurance has cleverly benchmarked their reimbursement to a percentage of the Medicare rate which continues on its downward spiral. The Centers for Medicare and Medicaid Services (CMS) and the commercial carriers have taken advantage of physicians because the vast majority of us have a social conscience and truly practice medicine for the benefit of the patients and not primarily for the dollars. Therefore, even with the current cuts we continue to see these patients because it is the moral and right thing to do.

Compounding these "losses" are inflation and cost of living increases. Physicians are at a net loss of income if they care for only Medicare patients. Years ago the Marshfield Clinic proved that the cost of caring for a Medicare patient exceeded the reimbursement for the physician providing such care.¹ Greater than 50% of physicians are now estimated to limit Medicare patients in their practices.

One of my partners recently went to a county medical society only to hear the sobering news that CMS will continue to diminish physician reimbursement as long as access is not a problem. However, despite our protests and those physicians that have stopped seeing Medicare patients, the patients are not complaining. But that may

be changing as illustrated in a recent article in the *Philadelphia Inquirer* by Jane Von Bergen on December 29, 2006:

After 50 years as an Independence Blue Cross subscriber, retired electrical engineer Russell Philipp, 74, is taking his business elsewhere.

The region's largest health insurer eliminated Philipp's plan and suggested that he and his wife, Lois, switch to one that would cost more and cover less. But what bothers Philipp is that the Philadelphia-based nonprofit organization continues to report a growing surplus that topped a billion dollars last year.

"It really irks me to think they have the surplus and yet they keep raising their premiums and decreasing the coverage," said Philipp, who lives in Broomall.²

Clearly, the patients are beginning to feel the pinch. What can we do?

The current generation of Medicare patients were brought up to believe and trust their physicians. We must develop tools and take the time to educate this population. As the majority of this population is 65 or older, we need to take the extra time and effort to educate them on their power and rights. We must help them understand what is currently happening with the cuts and make them active participants in the process. We must convey that by allowing the current and future Medicare cuts it will drive physicians to stop taking Medicare patients therefore limiting their access to effective care as they grow older. We must offer statistics and scenarios that will affect them directly.

Frankly most of the Medicare population have no idea what Medicare reimbursements are and how they are affected. In a recent dis-

cussion with my brother who is quickly approaching Medicare age, he said "I had no idea. How can you do this?" It is now time that we stop speaking to each other but take the issues directly to the patients and let them be the judge. We must arm them with information and encourage them to make their feelings known to their local and national politicians. It used to be taboo to discuss economics with patients, but no longer.

If we look at some common spine procedures, the declining reimbursement trend is obvious. **Table 1** is a brief listing of a few common codes and their Medicare payment comparing 1997 (conversion factor \$40.96) and 2006 (conversion factor \$37.90). Although the conversion factor fell "only" 7%, the payments fell more because of changes in relative value units used in the calculations.³

Prior to the mid 90s, physicians could economically justify the lower Medicare rates. However, now that private insurance is at a percentage of Medicare reimbursement and often times is less, this situation begins to tax even the best intentioned physician and most efficient practices. There will be a time when your practice may no longer be able to afford to care for Medicare patients. I have not yet reached that point, because I think about my parents and relatives, and who

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would take care of them. What about us when we get older? Will quality care be available to us? On one hand the best business decision may dictate that we do not see Medicare patients, but these are our parents, grandparents, aunts and uncles, and my conscience will not allow me to drop Medicare patients. Unfortunately the insurers and government look at Medicare as a business without a face, without emotional and physical suffering. Is it fair that our Medicare patients, the generation that raised us and made our country great, be treated as second class citizens?

For now, we must do much more to educate our patients in order to start a grassroots movement to pressure lawmakers to help repair this very broken system. NASS has been active through our Advocacy efforts, but we have not done enough. I am asking all of you

to submit your ideas for an "in-office education program" which patients can view in our waiting rooms. A computer or web-based presentation would be ideal, for example, and could allow instant access to lawmakers much as the Legislative Action Center does at our Advocacy booth during the annual meeting or year-round on the Web.

All NASS members' offices need to present unified and effective education. Today's physicians are not just healers—now we must take on more and more the role of educators.

Please send your ideas for patient education/advocacy to Eric Muehlbauer (Muehlbauer@spine.org).

References

1. Marshfield Clinic. Testimony on Medicare's Geographic Cost Adjusters before The Subcommittee on Health of the Committee on Ways and Means U.S. House of Representatives, 107th Congress. July 23, 2002. Available at: <http://waysandmeans.house.gov/legacy.asp?file=legacy/health/107cong/7-23-02/107-85final.htm>
2. Von Bergen JM. New health plans, old woes. *Philadelphia Inquirer*. December 29, 2007.
3. Centers for Medicare & Medicaid Services. *2006 CMS Annual Medicare Fee Schedule*. Baltimore, MD; CMS, US Department of Health & Human Services; 2006.

Table 1. Comparison of Medicare Reimbursement Rates for Selected Common Spine Procedures, 1997 and 2006

Procedure	1997	2006	% Decline
	Reimbursement	Reimbursement	
22554 Anterior cervical fusion	\$1662	\$1342	19%
22612 Posterior lumbar fusion	\$1801	\$1504	16.5%
22630 PLIF (lumbar interbody)	\$1705	\$1485	13%
63030 Lumbar discectomy	\$1205	\$ 888	26%
63047 Lumbar laminectomy	\$1408	\$1051	25%
63075 Anterior cervical disc	\$1609	\$1369	15%