Books

Miriam J. Laugesen. ***Fixing Medical Prices: How Physicians Are Paid.*** Cambridge, MA: Harvard University Press, 2016. 288 pp. $35, hardback

Once upon a time American physicians had it all. Overcoming modest beginnings, internal divisions, and myriad rivals, during the 20th century doctors in the United States achieved "professional sovereignty" (Starr 1982). They secured extraordinary levels of clinical and financial autonomy, as well as social prestige and public deference, and through the American Medical Association (AMA) exerted substantial political influence over health policy making. Organized medicine had a crucial role in shaping the major institutions of American health care, including private insurance and payment policies that reimbursed doctors on a fee-for-service basis with scant oversight or concern for costs. Such policies gave physicians "maximum control over their incomes," while "free choice of doctor by the patient" liberated physicians from restricted networks and limited insurers' bargaining power (Enthoven 1993: 25). The AMA fiercely protected these prerogatives, fighting against national health insurance and any initiative (from federally funded maternal and child health care to prepaid group health plans) that it deemed to be a slippery slope to socialized medicine or a threat to physicians' economic and professional interests.

Alas, at least from the medical profession's perspective, the fairy tale did not last. In 1965, Congress enacted Medicare and Medicaid, giving

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the government a powerful presence in health insurance. Initially the medical profession accommodated these programs, which were designed and administered in ways that conciliated physicians (Starr 1982). Medicare began by effectively writing a blank check to the medical industry, which discovered that this ostensible program of socialized medicine actually paid quite well. Eventually, though, the rising costs of health care led to a revolt from both public and private payers that challenged the inflationary conventions that physicians had established. With the advent of prospective payment in Medicare and spread of managed care in employer-sponsored insurance and Medicaid, doctors faced growing intrusions into their clinical decisions and new limits on payments. The medical profession went from dominating government and corporations to being subordinate to the demands for cost containment from both sectors. The "irony of success" (Light 2004) was that American physicians had shaped medical care delivery and insurance to reflect their interests, but those arrangements proved fiscally untenable, setting the stage for their undoing. The market had previously been a lucrative haven for the medical profession, but now market forces sought to discipline medicine, with competition invoked as a way to curb the excesses and inefficiencies generated by physicians' "guild system" (Enthoven 1993). Meanwhile, the political influence of organized medicine appeared to wane as doctors splintered into various specialty societies, reducing the AMA's clout, while public trust in and deference to the medical profession eroded (Starr 1982).

The history of the American medical profession often is told through this prism of "paradise lost." Miriam J. Laugesen's landmark book, *Fixing Medical Prices: How Physicians Are Paid*, offers a powerful corrective to the narrative that organized medicine's power has precipitously declined.[1] Laugesen argues that the growth of payment regulation has "afforded the profession more influence, not less" (7) by creating opportunities for physician groups to influence, often away from the public spotlight, the implementation of complex policies that have major implications for doctors' income. She explores the political dynamics surrounding Medicare's process for setting and updating physician fees, with a focus on the critical role played by the Specialty Society Relative Value Scale Update Committee. The RUC, as it is commonly known, advises the Centers for Medicare and Medicaid Services (CMS) on the relative value units that are the foundation of the Medicare's fee schedule for physicians. Relative value units measure, in large part, physician work, encompassing "the relative

1. In the spirit of disclosure, Dr. Laugesen and I have collaborated on several articles.

levels of time, effort, skill, and stress associated with providing each service" (MedPAC 2017: 1). When Congress adopted the Resource Based Relative Value Scale payment system in 1989, which built on a framework developed by Harvard economist William Hsaio, it was seen as a way to base fees on objective measures of services' costs and complexity, as well as a means to correct imbalances in remuneration that favored expensive specialty services over primary care.

As Laugesen skillfully demonstrates, neither of those aspirations has been realized. Organized medicine has greatly influenced the setting and updating of Medicare physician fees. Indeed, the AMA operates the RUC (the events that led to it gaining this privileged position remain a mystery), which amounts to the "fox guarding the hen house" (114). CMS, which lacks adequate resources and has incentives to cooperate with physician organizations, largely abides by the committee's recommendations. Consequently, the federal government effectively cedes a major area of Medicare payment policy to physician groups that, collectively, have tens of billions of dollars at stake in how program fees are revised. Medicare's system of administered pricing is, Laugesen argues, largely administered by the medical profession. The RUC justifies this incongruous arrangement partly by casting itself "as a panel of experts that relies on evidence-based decision making" (129), including surveys of physician work effort. It also has adopted policies, such as a prohibition on physicians voting on or advocating for services from their own specialties, that aim to promote members' independence while avoiding conflicts of interest and the appearance that the committee simply represents the interests of the specialties that comprise its membership. Additionally, RUC members commonly argue that they are redistributing Medicare fees among different medical specialties rather than increasing overall spending because the RUC works within budget neutrality requirements that create a "fixed pie" (90) of program expenditures.

Laugesen's extensive research punctures gaping holes in these self-serving defenses of the RUC. At times, the committee's thoroughly politicized operations more closely resemble the television show *Survivor* or the UN Security Council than an expert panel. There are high-stakes debates over who should sit on the RUC—22 specialties have permanent seats—with primary care doctors complaining about the overrepresentation of surgeons and proceduralists. Specialties lobby and form alliances with other physician groups. They also make unofficial deals to advance mutual interests, such as ignoring other societies' overvalued services so as to avoid "retaliation and scrutiny" of their own overvalued services (148). Medical

societies work assiduously to protect bread-and-butter services that generate substantial revenue while occasionally offering up "sacrificial codes" to help create a credible reputation so they can safeguard the big-ticket items. Nor are committee members "autonomous physicians acting as free agents" (138). Pretensions of independence are hard to square with the fact that the RUC largely comprises representatives from specialty societies that pay for their members' travel to its meetings, as well as, in some cases, stipends and sizable per diems. As Laugesen notes, the RUC "was created by specialty societies for specialty societies" (136).

Moreover, the physician work surveys that the RUC relies on in making judgments about relative value updates are plagued by methodological problems, including issues with sample size and response rate, inaccurate (and often inflated) estimates of physician work effort, and the sponsorship of these surveys by specialty societies whose "advocacy activities [are] focused on gaining higher reimbursements" (159). Not surprisingly, medical societies selectively interpret survey data to conform to their views of how services should be valued, and "when a specialty society does not like its own data, it may form an 'expert panel' to develop alternative estimates that are used to override the survey data, although it has to provide both to the committee" (165). The RUC tends to "overvalue and increase (rather than decrease) work values" (130); in turn, these discrepancies between the actual time physicians spend on a service and the higher time values that the RUC estimates result in higher fees. The inflated estimates are more likely to occur for surgical and procedural services, which helps to explain the persistent gap between those specialties and primary care. The RUC also has a bias, reflecting the interests of specialty societies, toward reviewing ostensibly undervalued codes. Laugesen convincingly shows that the notion, evidently widely held by RUC participants, that the update process is "objective" and that the committee's recommendations to CMS reflect "survey data and scientific expertise" (172) is an illusion.

If the RUC is not really an expert panel, is the persistent pursuit of higher fees by medical specialties at least constrained by the budget neutrality rules that are supposed to govern physician payment? According to Laugesen, the conventional wisdom that Medicare spending on physician services is a "fixed pie is at least partly a myth" (118). The restraints on overall Medicare expenditures that were supposed to complement the Medicare Fee Schedule were severely weakened and eventually rescinded. Meanwhile, shifting utilization patterns that favor more lucrative services undercut the impact of reductions in other services. Moreover, revisions defy gravity:

"Generally speaking, codes go up rather than down" (114). "Over time," Laugesen reports, "relative value units are increasing" and "fee increases directly account for a significant proportion of increases in Medicare expenditure" (193). More highly specialized services stand a better chance at having their values increased since the budgetary impact of such changes appears smaller than increases for more common services. Because private insurers widely use Medicare's fee schedule, the RUC has tremendous influence over physician payment, and the price distortions it produces are thus reproduced across American medicine.

The RUC has previously attracted criticism for its biases, inaccurate estimates of physician work, and role in generating distorted prices. Yet *Fixing Medical Prices* is the most comprehensive, compelling, and systematic account of the RUC that has ever been produced. It makes major contributions to our understanding of physician payment, Medicare policy, and health care politics. The RUC has largely existed as a "black box," with little known about its inner workings. Laugesen takes us deep inside that box to view how prices are actually decided in Medicare. The strength of her analysis is buttressed by a unique synthesis of key-informant interviews, quantitative data, and reports from the author's attendance at RUC meetings. In particular, the access to RUC proceedings, its members, and other participants in the update process that Laugesen secured is striking; the resulting insights help her paint a rich, illuminating portrait of the committee's operations and problems. The book is a model of how to combine rigorous policy analysis with sophisticated political analysis.

And what of the purported decline in the medical profession's political power? *Fixing Medical Prices* complements other recent work (Patashnik, Gerber, and Dowling 2017) in documenting how physicians have sustained their political and economic power amid growing pressures to curtail spending increases and challenges to their clinical autonomy. There is no question that organized medicine has used the RUC to shape Medicare payment and that it has the resources and expertise to bend the highly technical, relatively quiet terrain of rule making and regulation to its interests. The repeal in 2015 of Medicare's Sustainable Growth Rate formula for updating physician fees—a long-sought goal of the AMA and other specialty societies—further attests to organized medicine's political resilience.

Still, it may go too far to argue, as Laugesen does, that "the House of Medicine's political power and influence have not diminished" (9). Organized medicine's power could still be strong even if it has slipped from

its apex. The AMA has captured the RUC. Yet many major policy developments since the 1960s—including the enactment of Medicare, rise of managed care, adoption of prospective payment, and passage of the Affordable Care Act—happened either over the objections of the medical profession or without their decisive influence (though organized medicine did work to hasten the decline of managed care). As *Fixing Medical Prices* shows, the influence of physicians over payment policy remains strong, but that influence does not necessarily extend to the same degree to all areas of health care policy. It is also important to note that the regulatory capture story does not capture much of what has happened in Medicare. Since the advent of payment reforms in the 1980s, excess cost growth in Medicare has declined substantially, and in recent years Medicare per-enrollee spending has, remarkably, remained relatively flat due largely to changes initiated by the Affordable Care Act. For all the problems with the Medicare Fee Schedule and RUC, arguably the most important story in Medicare over the past 35 years is the adoption of cost containment measures within the program and the success, however modest, those reforms have had in reducing rates of spending growth.

Nonetheless, policy makers have had more success slowing Medicare expenditure growth for hospitals than for physicians, and the question of how to contain increases in the volume and intensity of outpatient services remains a puzzle that the program has yet to solve. Indeed, during 2000–2016 most of the increase in spending on services under the Medicare Fee Schedule was attributable to growth in volume rather than to payment updates. Effective, systemwide price regulation, the foundation of other nations' cost control regimes, remains elusive in the United States. *Fixing Medical Prices* demonstrates just how far the United States has to go if it is to contain health care spending and create a sensible, fair scheme for paying physicians.

—Jonathan Oberlander, University of North Carolina at Chapel Hill

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Jonathan Oberlander is professor and chair of social medicine in the School of Medicine and professor of health policy and management in the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill.
oberland@med.unc.edu

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