PRI CENTER FOR MEDICAL ECONOMICS AND INNOVATION

ISSUE BRIEF

It's Time for Medicare to Stop Shortchanging Physicians

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JUNE 2025

A Pacific Research Institute Publication

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June 2025

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Executive Summary

Over the past ten years, the compensation of physicians has failed to keep up with inflation let alone the cost of running a practice. Medicare's uneconomical reimbursement policy is driving this trend. Since declining compensation rates are exacerbating the problem of growing physician shortages, it logically follows that Medicare's current physician reimbursement rates are below their market value.

Not only is Medicare's physician compensation uneconomical, but it also discourages innovation and encourages lower-cost independent practices to merge with high-cost hospital systems. The unintended result is higher overall health care costs.

Rather than a piecemeal approach to reform, the more efficient way to address the problems with the physician reimbursement system is to turn Medicare into a cash-based benefit system. This direct payment option would fund health savings accounts (HSAs) for seniors, enabling them to receive their Medicare benefits in the same manner that they receive their Social Security benefits. At current expenditure levels, Medicare could provide beneficiaries with $15,151 that they could then use to purchase health insurance and directly pay for their health care needs.

> "Rather than a piecemeal approach to reform, the more efficient way to address the problems with the physician reimbursement system is to turn Medicare into a cash-based benefit system.

It is unlikely that transformational direct payment reforms will be implemented in the near-term. Consequently, near-term reforms to address the problem of underpaying physicians are required. Such changes should include:

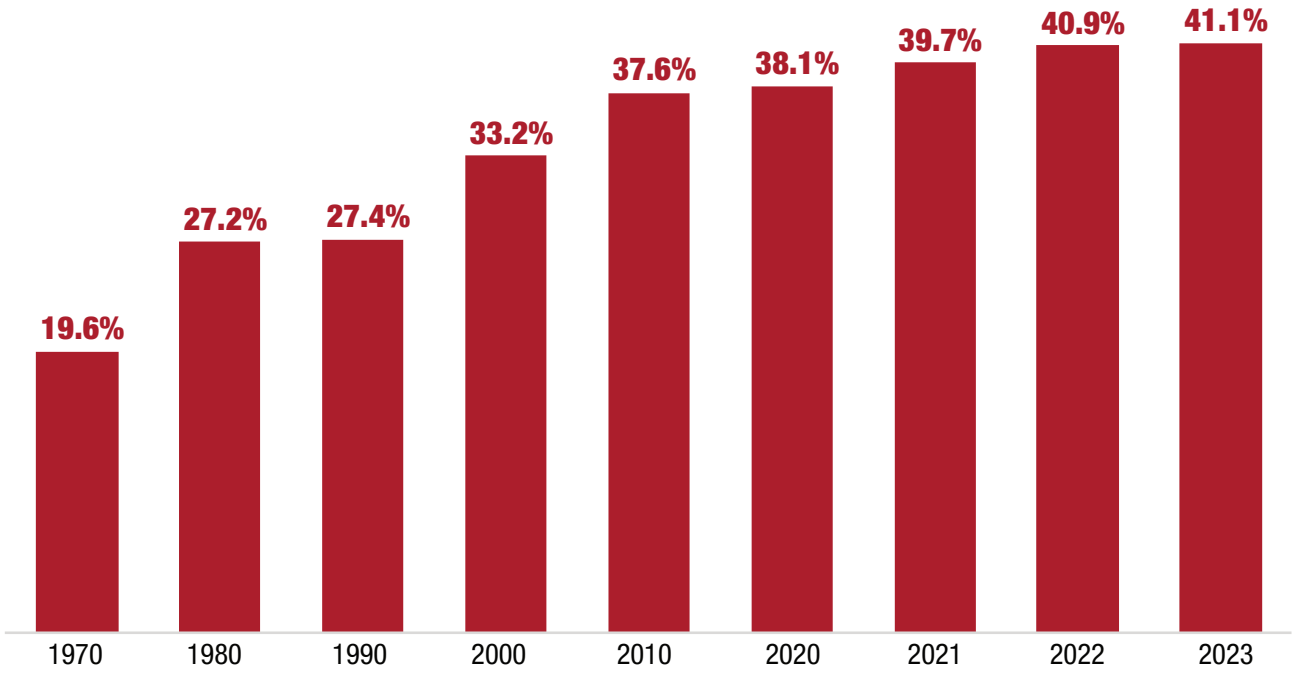
- Indexing physician payments to the cost of running a medical practice to prevent continued income erosion
- Enacting a site neutral payment system
- Supporting value-based care experiments

Given current demographic trends, Medicare and Medicaid's share of total health care expenditures will continue to grow for the foreseeable future. As a result, it is essential to address the problems created by Medicare's underpayment of physicians sooner rather than later.

Introduction

The Medicare and Medicaid programs now account for more than 41 percent of total health care expenditures, which is their largest share ever, see Figure 1. Considering the spending from other government programs (such as Veteran's Health) and the impact from the mandates that the federal government imposes on the private sector, federal government policies now control or influence way more than half of all national health care spending. Given this reality, it logically follows that much of what ails the U.S. health care system is due to federal government policy. The adverse consequences arising from Medicare's current approach to reimbursing physicians exemplifies the potential negative impacts.

Figure 1.
Medicare and Medicaid Share of Total Health Consumption Expenditures



Source CMS

Due to Medicare's growing share of total health care payments, Medicare's flawed physician reimbursement system has a large and increasingly negative effect on the delivery of health care in the U.S., which the PRI publication *Shortchanging Physicians*[1] examined. The study argued that Medicare's current physician reimbursement rates are below their market value. And just like with rent control laws, adverse consequences follow when the government forces prices to uneconomical levels.

Pricing Below Market Value

In the case of Medicare's physician reimbursement rates, several disconcerting trends convincingly argue that the government has forced current prices below their market value.

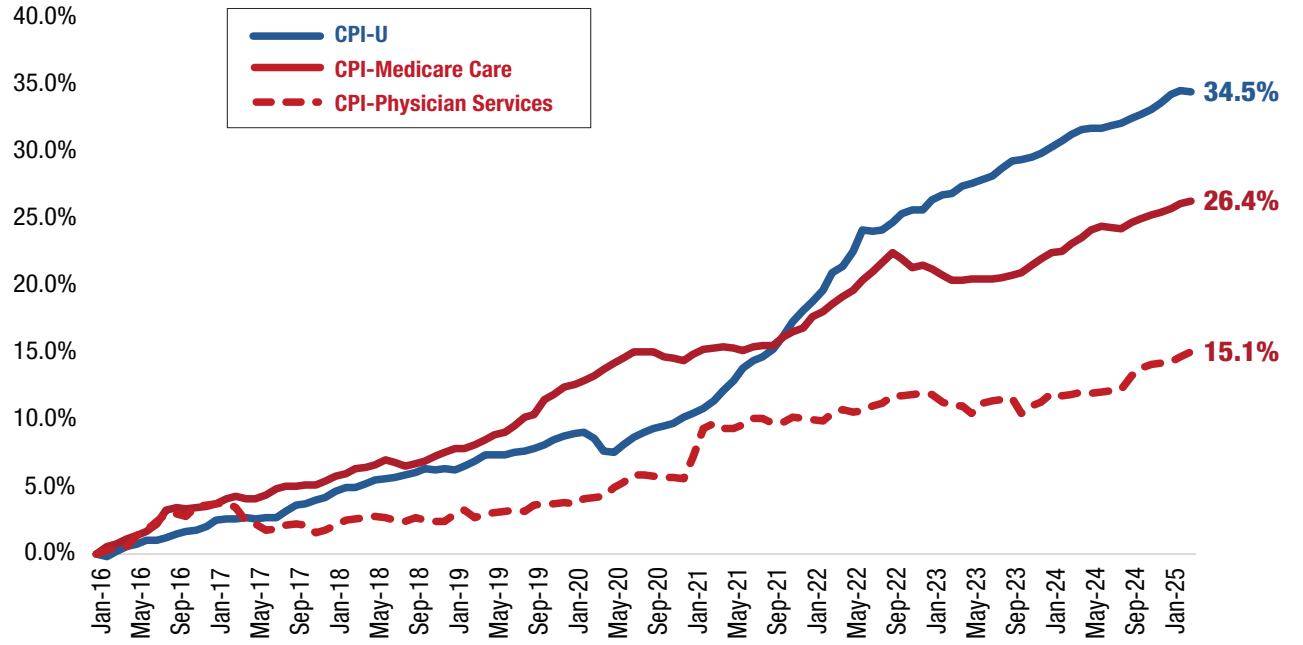
To start, reimbursement rates have failed to keep up with the cost of running a medical practice – let alone reward truly innovative ways to deliver care. In fact, some doctors report they lose money when treating Medicare

patients.[2] A survey of independent doctor practices found that 68 percent cited "low reimbursement rates" as a primary threat to independent practices; 50 percent cited "declining margins/profits" as a primary threat.[3]

Analyses by the American Medical Association (AMA) also confirm that the prices received by doctors are falling relative to the costs of running a medical practice. The AMA analysis evaluates the payments physicians received relative to the costs of running a medical practice as measured by the Medicare Economic Index (MEI). According to the AMA, the MEI in 2025 is nearly 60 percent higher than in 2001.[4] Actual payments to physicians have grown much slower than these cost increases, causing a 33 percent decline in Medicare's inflation-adjusted payments to physicians.

Reimbursement rates have also failed to keep up with inflation. Figure 2 illustrates that this has been a problem for the past decade and continues to persist today by comparing the growth in prices for physician services to the prices for overall medical care and the broader inflationary environment.

Figure 2
Growth in Prices for Physician Services Has Fallen Relative to the Prices for Medical Care and Overall Inflation



Source BLS

Figure 2 uses January 2016 as the basis for comparison due to the adoption of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. This Act changed the way Medicare compensated physicians and attempted to transition Medicare aware from the fee-for-service model toward value-based care models. Since the adoption of MACRA, the compensation of physicians has lost significant ground compared to overall inflation.

Since January 2016, inflation is up 34.5 percent compared to a 26.4 percent increase in medical care prices and a much lower 15.1 percent increase in the prices for physician services. The consumer price index data indicates that physician incomes have been declining relative to the overall cost of living for the past decade. Importantly,

the price increases for physicians have lagged the broader inflationary environment even prior to the 2021-22 inflationary surge. Also noteworthy is that, thanks to the surge in inflation, price increases for overall medical care are lagging the broader increase in prices.

Potential market-based justifications for the erosion of physician pay do not explain the current trends. For instance, market forces will drive down the prices for any good or service if consumer demand for the product is falling. Given the aging baby boomer generation, it is infeasible that demand for medical services is decreasing; therefore, the decline in reimbursement rates is not due to falling demand.

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Prices can also decline when there is a huge increase in supply. However, the data do not indicate that there has been a huge surge in the number of qualified doctors – in 2023 there were 25.4 active physicians in patient care.[5] This rate is down from the level in 2019 and has fallen back to the levels that existed back in 2009. Consequently, market forces do not justify a supply-driven fall in prices either.[6]

There are those pesky Medicare established prices, however. Basic economic logic foretells that product shortages will arise when the government sets prices below their market value. Considering the supply and demand trends, if the decline in inflation-adjusted prices coincides with a growing shortage of doctors then it is likely that Medicare’s current reimbursement rates are imposing an uneconomical price cap on physicians’ pay. The evidence supports this theory.

In its 2024 analysis, the Association of American Medical Colleges (AAMC) estimates that there is currently a shortage of 37,000 physicians that could grow to up to 86,000 by 2036.[7] While the AAMC cites other factors helping to drive these declines, such as the larger number of retiring doctors due to the aging of the baby boom generation, there are also large numbers of physicians who are choosing to change careers.

While acknowledging that the shortage is a multi-faceted problem, a McKinsey & Company September 2024 survey on the growing physician shortage found that “69 percent of respondents flagged a desire for higher remuneration” when “asked about factors that influence their decision” to stop practicing medicine.[8]

With respect to future doctor shortages, there is also a distressing decline in medical school applicants. As reported by AAMC, the total number of medical school applicants in 2024 declined 1.2 percent, which was the third straight year of declines.[9] Applicants are now at their lowest level since 2017-18.

The worsening physician shortage creates serious health risks for patients. These include longer wait times for appointments, less access to specialty care, and shorter doctor visits.[10] According to *Axios,* “the most frequently cited specialties with long wait times included neurology (26%), ear, nose, and throat (26%), psychiatry (20%), and OB/GYN (17%). Primary care stood at 19%.”[11] The risks are also much higher that there will be larger numbers of medical errors and more misdiagnoses or missed diagnoses causing a higher rate of low-quality treatment. These risks will be more acute for people living in rural areas, who will have a higher chance of living in areas deemed “medical deserts” or regions that lack sufficient access to pharmacies, primary care providers, and hospitals.

In addition to aggravating the growing doctor shortage problem, the financial vibrancy of the traditional doctor-owned family practice is also declining. According to the AMA Physician Practice Benchmark Survey, "between 2012 and 2022 the share of physicians who work in practices wholly owned by physicians – private practices – dropped by 13 percentage points from 60.1 percent to 46.7 percent. Practice size has also changed, with a continued redistribution of physicians from small to large practices."[12]

The combination of declining financial viability of independent doctor practices and growing doctor shortages indicates that Medicare's physician reimbursement rates are well below their market values. The continuation of Medicare's uneconomical pricing indicates that the concerns we raised in *Shortchanging Physicians* remain relevant. In the case of physicians, uneconomical reimbursement rates are a driving factor in the growing doctor shortage problem.

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In recognition of the long-standing erosion of physician pricing under Medicare, the Consolidated Appropriations Act of 2024 increased payments by 2.9 percent for all fee schedule services between March 9, 2024 and December 31, 2024.[13] Despite acknowledging that serious consequences were arising due to the government price controls, average payments to physicians and clinicians declined by 2.93% effective January 1, 2025.[14] In other words, the problem of Medicare setting below market rates continues to plague the health care system.

Considering these consequences, fixing Medicare's flawed reimbursement policy is essential. The reality that the average reimbursement rate is once again declining despite the broad-based recognition that Medicare's controlled prices are uneconomical demonstrates that temporary fixes are insufficient to address the problem. Instead, sustainably addressing the problem of Medicare undercompensating doctors requires fundamental reforms to the Medicare payment model.

The Current Physician Reimbursement System Is Fatally Flawed

It should not be surprising that the current reimbursement system is failing. Its fatal flaw is the system's goal "to use a 'science-based' approach to simulate a hypothetical market to determine equitable physician payment rates."[15] CMS's scientific method for determining the prices for a medical service is complex, subjective, and destined to fail. Government efforts to simulate market outcomes do not work because bureaucracies cannot replicate the knowledge and incentives that are the fundamental drivers of the market process. To be efficient, markets require the natural give and take between actual suppliers and actual demanders.

From a provider's perspective, the market process enables physicians to receive prices that reflect their economic value and creates incentives for providers to find new and more efficient ways to deliver care.

Medicare's current pricing process sets prices below a doctors' economic value and does not reward physicians for providing care more efficiently. In fact, the current system incentivizes provider consolidation and discourages doctors from staying in private practice. It also feeds inefficiencies in the broader health care system. For example, under the current reimbursement system, Medicare reimburses hospitals more than independent physician offices for performing the same service. This reimbursement system incentivizes independent practices to merge

with hospital systems, which is precisely what has occurred. The consolidation of lower-cost physician practices into higher-cost hospital systems is driving up overall health care expenditures and reducing patient choice – the exact opposite of what a free market would incentivize.

Disincentives such as the above pervade the current Medicare payment system. These disincentives also mean that the bureaucratic price setting process does not "simulate" the market incentives of health care providers – the system does not account for the interests of the supply-side of the market.

The same is true for the demand side. In all health care markets, the ultimate demanders are patients. They are the only ones able to express how much they value alternative forms of care. This reality means that, for the market to maximize value for patients, patients must be empowered to express which services they prefer. But it is simply impossible for patients to express how much they value alternative health care services when they are trapped in the current bureaucratic morass. In fact, the entire physician repayment system is designed to block patient input. In place of patients expressing their desires, the Medicare physician pricing system uses a system as Orwellian as it is devoid of actual patient input.

"The reality that the current Medicare physician payment system is turning to price controls to keep costs under control is an indication that the system is failing and fundamental reforms are required.

Given that Medicare's physician price setting process does not include the input from the actual suppliers and demanders in the market, it is impossible for the process to accurately "simulate" market outcomes. It is not surprising, consequently, that the current reimbursement rates are set at prices well below market value.

The third driving value for the physician price setting process, which has not yet been discussed, is to maintain budget neutrality. And given Medicare's precarious finances, budget discipline is imperative. Socialized health care systems struggling to control costs inevitably resort to uneconomic price controls, which is exactly what Medicare is doing.

The problem arises because patients bear a large burden when governments impose price controls on health care that include longer wait times, less access to care, and lower quality health care. The reality that the current Medicare physician payment system is turning to price controls to keep costs under control is an indication that the system is failing and fundamental reforms are required.

The Long-term Fix Empowers Sustainable Well-Designed Markets

Rather than a piecemeal approach to reform, the more efficient way to address the problems with the physician reimbursement system is to comprehensively address Medicare's broader deficiencies. Turning Medicare into a cash-based benefit system that funds health savings accounts (HSAs) for seniors, as recommended by Silver and Hyman (2024), would efficiently achieve this goal.[16]

In other words, rather than relying on a third-party payer system, Medicare benefits should be based on a direct payment system. The direct payment option changes Medicare's structure such that beneficiaries receive their

health care benefits in the same manner that they receive their Social Security benefits. Silver and Hyman specifically propose that, in addition to traditional Medicare and Medicare Advantage, seniors should have access to a third, direct payment option, which gives

> *Medicare beneficiaries' control of the dollars the agency doles out. Instead of paying bills from providers as it currently does, Medicare would fund health savings accounts and beneficiaries would use those funds to purchase treatments and to secure insurance against catastrophic needs. If adopted, our proposal would convert 66 million Medicare beneficiaries into an army of self-paying consumers who, caring about both quality and price, would flock to efficient providers while avoiding those who overcharge or underdeliver.*

To give a sense of the size of the benefits, the authors state that

> *Medicare covers about 66 million people, most of whom are seniors. In 2023, the program spent about $1 trillion on health care for this population, an average of $15,151 per person. This is also the average amount that would have been deposited into Medicare beneficiaries' HSAs had our proposal been in place.*

Under this system, patients and physicians gain the ability to circumvent Medicare's current uneconomical pricing system. Physicians would be able to set prices that reflect value, and patients would be empowered to directly judge whether those prices achieve that goal. Further, the system incentivizes providers to find new and better ways to serve patients with the goal of expanding value and reducing costs.

Doctors would benefit from reduced administrative costs and, with electronic payment systems connected to patient HSAs, immediate payment. With sufficient uptake, the beneficial incentives created by a direct payment system would meaningfully address many of the problems plaguing the Medicare system including the uneconomical reimbursement of physicians.

> "Rather than relying on a third-party payer system, Medicare benefits should be based on a direct payment system.

Just as Medicare's inefficiencies harm the overall health care system, adding a direct payment option into Medicare could create benefits for the overall health care system. The opportunities to improve the health care system, including physician reimbursement rates, are even greater if the direct payment reform was offered to other populations including Medicaid and the commercial market. Toward this goal, Silver and Hyman would extend this direct purchase system to Medicaid and Veterans Health programs. Reforms that address the tax inequities favoring employer-sponsored health plans and promote broader use of HSAs can offer these benefits to the commercial health insurance market.

Fundamental reforms that establish well-functioning health care and health insurance markets rather than attempting to "simulate a market" will significantly improve the efficiency of the health care system, enable physicians to set prices equal to their market value, and promote a more vibrant and innovative health care system. It is, consequently, an efficient way to address the current problem of uneconomical payments for physicians.

Near Term Reforms to Address Pressing Pricing Inefficiencies

People do not live in the long term and it is likely unrealistic to expect that direct payment reforms could be implemented in short order. Given this constraint, reforms that directly alleviate the consequences from the current uneconomical physician pricing can help address the problems arising from uneconomical physician reimbursement in a timely manner. Ideally, such reforms will be a first step toward enacting the ultimate goal of transforming the health system from a third-party payer system into a direct party payer system.

Index Physician Payments to Inflation

While experimentation with value-based models will likely continue, it is likely that the fee-for-service (FFS) model will remain a major part of the Medicare payment system. The FFS model reimburses physicians based on the type and number of specific medical services that have been provided.

Ensuring that inflation does not erode the value of physicians' Medicare payments under the FFS model requires the indexation of payment rates to inflation. Indexing government payments to inflation is not a novel concept. Medicare already ties its payments to hospitals, hospices, and skilled nursing centers to inflation. In fact, physician reimbursement is the only Medicare service area that lacks inflation adjustments. Tying federal payments to inflation is also commonly used in government programs outside of Medicare, such as tying Social Security benefits to inflation.

Indexing government payments to inflation makes sense because (1) inflation erodes the purchasing power of people's incomes; and (2) inflation is ultimately a policy choice. Since inflation is both a hidden tax and a stealth method for the government to undermine its obligations, without inflation indexation, the government has the unique ability to lower the real value of its obligations and change policy by stealth. Such actions undermine the foundations for a prosperous economy and are antithetical to the principles of good governance.

To prevent the continued erosion of the real value of physician payments, physician reimbursement rates should be indexed to an appropriate cost index. For instance, Medicare maintains the Medicare Economic Index (MEI), which "is a measure of practice cost inflation that was developed in 1975 to estimate annual changes in physicians' operating costs and establish appropriate Medicare physician payment updates."[17] Just as it makes sense to index Medicare's payments to hospitals to inflation, or Social Security payments to beneficiaries to changes in consumer prices, it makes sense to prevent inflation from eroding the incomes of physicians.

Properly indexing the Medicare payment rates to actual market-based prices will help ensure that the value of Medicare's reimbursement rates does not erode over time. This reform will also require Congress to remove the budget neutrality requirement for Medicare physician payments.

Enact Site Neutrality Payment System

Indexing physician payments to inflation is an insufficient reform. The current practice of paying different reimbursement rates for the same services incentivizes the consolidation of physician practices toward higher cost providers. Specifically, since Medicare pays higher rates to hospitals than independent practices when providing the same medical service, hospitals can increase revenues by acquiring independent practices. Once acquired, the services that were previously reimbursed at a lower rate are suddenly transformed into a higher priced service.[18] Therefore, the current practice of changing the physician payment rate depending on where care is delivered is causing overall health care expenditures to increase.

Given the need to control health care spending, it is essential to remove the bias toward providing care in the more expensive settings. Enacting a site neutral payment system that pays the same compensation for the same service regardless of where it is delivered will achieve this goal. This reform will remove the incentive to deliver care in higher-cost settings and will help lower the growth rate in overall Medicare expenditures. These cost reductions will help impose greater cost discipline on the Medicare program and offset the potential increase in costs from indexing physician payments to inflation.

From a patient perspective, site neutrality payments will remove one disincentive that is forcing independent practices out of business. Patients will benefit as a result because greater choice in the delivery of care will be maintained and, ideally, expanded.

Support Value-Based Care Experiments

The limits of the dominant FFS model are well documented. First, FFS incentivizes an overconsumption of health care services that inflates overall health care expenditures. Second, FFS does not directly link payments with the quality of care delivered or patient outcomes. This disincentive discourages potential innovations that could increase the quality of the care while reducing overall costs. Third, the FFS model encourages fragmented care, which can also become an obstacle to better health services. Due to these flaws, Medicare has been advancing value-based care models.

Beyond the broader impacts on costs and quality, value-based care models also have the potential to address the problem of undercompensating doctors. However, it is important to recognize that the manner in which these models are implemented matters and the results of several value-based care delivery models have been disappointing.

> “When implemented well, value-based care enables doctors to earn higher incomes when they deliver better care while reducing their administrative burdens.

When implemented well, value-based care enables doctors to earn higher incomes when they deliver better care while reducing their administrative burdens. Additionally, value-based care models have the potential to control overall spending by avoiding the disincentives of the current fee for service model.

While the approach for value-based care will vary, the typical model leverages bundled payments and coordinated care models to find more efficient ways to deliver care to patients. With reimbursement received as a bundled payment, the total revenues of the clinic, hospital, or practice no longer depend on the volume of services provided. Physicians are, consequently, better able to focus on the quality of care. Coordinating care across specialties, if designed well, will help minimize the problem of care fragmentation. Studies have found that care fragmentation will often increase costs while delivering inferior health care services.[19]

Medicare currently has many value-based delivery models that are in different stages of availability to patients and meeting with different levels of success.[20] Where successful, value-based offerings can help address several of the flaws plaguing Medicare, including the uneconomical reimbursement of physicians. Supporting continued experimentation and opening successful value-based care models to broader populations is an important strategy for helping address the problems associated with uneconomical physician pricing.

Conclusion

Setting prices below market rates creates large negative consequences, whether it is the market for rental apartments or health care. The growing doctor shortages and declining financial viability of independent physician practices are indications that the long-term decline in Medicare's physician reimbursement rates has pushed compensation to below market rates. The consequences are threatening to worsen the growing doctor shortage and offer patients lower quality health outcomes.

Addressing the problem of uneconomical physician repayment is an important priority, consequently. The ideal reform creates a direct payment option that replaces the simulated artificial market the Medicare bureaucracy relies on today with an actual market that establishes health care prices – including physician prices. Outside of this fundamental change, reforms should directly address the under-compensation problem by indexing physician reimbursement rates to inflation and instituting a site neutrality payment policy.

Given current demographic trends, Medicare and Medicaid's share of total health care expenditures will continue to grow for the foreseeable future. As a result, the problems created by Medicare's underpayment of physicians will continue to worsen without effective reforms; and it is patients who will ultimately pay the highest price.

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Dr. Winegarden has 25 years of business, economic, and policy experience with an expertise in applying quantitative and macroeconomic analyses to create greater insights on corporate strategy, public policy, and strategic planning. He advises clients on the economic, business, and investment implications from changes in broader macroeconomic trends and government policies. Clients have included Fortune 500 companies, financial organizations, small businesses, state legislative leaders, political candidates and trade associations.

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