Opinion

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What Is the RUC—and Why Do We Care?

In 1965, when President Lyndon B. Johnson signed the legislation that created Medicare, the American Medical Association was not happy. The AMA had opposed publicly funded health insurance and, in 1961, it embarked on "Operation Coffee Cup." The Woman's Auxiliary of the AMA was charged with hosting gatherings of their friends to listen to a recorded message from Ronald Reagan. The future president warned of the dangers of socialized medicine, and the "ladies" were provided stationery to write members of Congress, urging them to oppose the proposed legislation. Despite these early efforts, the AMA now plays an important role in the administration of Medicare through the Relative Value Scale Update Committee, known as the RUC.

What is the RUC, how does it work, and why do we still need it? When Medicare was first created, physicians charged the program their "usual, customary, and reasonable" fees. However, by the 1980s, conflict about differences between payments to primary care and specialists led to the resource-based relative value scale. The RUC was created in 1991 to assign relative value units (RVUs) for the work that physicians do, and it is now an integral part of the Medicare payment system.

The RUC is an advisory committee that is composed of 32 volunteer physicians. All told, 22 medical specialty organizations have a permanent seat on the RUC, with an additional four seats that rotate between specialties. Though RUC recommendations have power, they are advisory—and, ultimately, CMS makes the payment decisions. Historically, CMS has accepted 90% of the RUC recommended payment values. Now, however, David Glasser, the Academy Secretary for Federal Affairs, reports that CMS accepts approximately 75% of the RUC recommendations.

Ophthalmologists know that there is sustained downward pressure on reimbursement for procedures. However, this year's cuts for strabismus surgery and MIGS felt especially draconian. The RUC recommended an additional $90 for insertion of a MIGS device when doing cataract surgery, a marked reduction from the previous reimbursement. Then, CMS proposed an even lower increment—for a reduction of 90%—but eventually accepted the RUC recommendation. This—plus the decreases in reimbursements for strabismus surgery and the repeated cuts to cataract surgery fees—led some to question the RUC process and to propose alternate pathways for valuing ophthalmology services. Yet the Academy continues to support the RUC process. Why?

The AMA-sponsored RUC process allows physicians to participate in valuing their own services. Because the family of medicine comes together in one organization to make recommendations, it allows medicine to speak with one voice on valuation. Overall, this gives medicine more power than it would have if we were fractionated and lobbying independently. Furthermore, because ophthalmology is a small specialty, our influence would be diluted by larger groups, especially primary care organizations. Some health policy experts argue that physicians should not be involved in setting their own reimbursement rates, but only physicians understand the nuances of comparing one procedure to another. Although the system is imperfect, David Glasser explains that "at the RUC we all play by the same rules, and no one gets special treatment."

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If we didn't have the RUC, how would Medicare payment decisions be made? Most likely the long-term employees at CMS who are policy experts would establish the rules and make the decisions. This would eliminate the unified voice of medicine, remove a process that is transparent, and diminish the interests of small specialties.

The "ladies" of Operation Coffee Cup were prophetic in some ways because they feared that physicians would lose autonomy. Yet Medicare has been a popular program, has allowed millions of older Americans to get care, and helped establish the health care industrial complex. We will continue to struggle with how reimbursement decisions are made, but the RUC allows us to participate in the process.