COMPARISON OF CURRENT CONGRESSIONAL PROPOSALS FOR CHANGING MEDICARE'S SYSTEM FOR PAYING PHYSICIANS

by

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SUMMARY

The Congress is considering proposals that would eliminate Medicare's current physician payment system and replace it with a Medicare fee schedule. Full implementation of the fee schedule would be several years away, but transitional steps toward a fee schedule might begin as early as 1990.

This paper describes the fee schedule reform proposals and the more immediate physician payment proposals included in reconciliation provisions for fiscal year 1990, as currently developed by the House Committee on Ways and Means (W&M), the House Committee on Energy and Commerce (E&C), and the Senate Finance Committee (SFC).

The paper also simulates the effects of the reform proposals and the proposals for 1990. For the simulations, physicians' claims data for a sample of enrollees in 1986 were used, after adjusting the data to reflect CBO's projections for 1990.

While the committees' reform proposals would be implemented in a budget-neutral way, so that there would be no change in Medicare's aggregate payments, physicians' Medicare receipts would fall somewhat. The fall in receipts would be largest under the W&M proposal because W&M would impose the tightest limits on balance-billing. Under all proposals: medical specialties would see their Medicare payments increase relative to current law, while payments to most surgical specialties would be smaller; physicians in urban areas would face reductions in payments, while those in rural areas would generally receive more from Medicare; and enrollees' out-of-pocket costs for physicians' services would fall.

Under the committees' proposals for 1990, payments to physicians would fall and enrollees' aggregate out-of-pocket costs would be unchanged or would increase slightly. The largest fall in payments at impact would occur under the W&M proposals, while the E&C proposals would generate the smallest reduction in payments. These results reflect the size of the Medicare savings each set of proposals would generate. For each of the packages, the cuts would be fairly uniformly distributed by geographic area, and would affect medical specialties less adversely than other physician groups.

COMPARISON OF CURRENT CONGRESSIONAL PROPOSALS FOR CHANGING MEDICARE'S SYSTEM FOR PAYING PHYSICIANS

Under the customary, prevailing, and reasonable (CPR) system by which Medicare currently sets payment rates for physicians in the fee-for-service sector, payment for each service provided is the lowest of the physician's actual charge, the physician's customary charge for that service, or the prevailing fee for that service in the community. Prevailing fees are based on the customary charges of all physicians in the community, but increases in prevailing fees above their values for 1973 have been limited by a nationwide index of earnings and office practice expenses called the Medicare Economic Index (MEI), or by lower values mandated by the Congress.

Dissatisfaction with the CPR system is widespread. Specific objections cited are that it:

- Induces inflation in fees;
- Encourages growth in the volume of services (either their number or their complexity);
- Does not appropriately reflect the costs of providing alternative services, with the result that physicians' decisions about training, location, and treatment practices are distorted in undesirable ways;
- Is difficult for patients and providers to understand; and
- Is cumbersome to administer.

In the budget reconciliation acts of 1985 and 1986, the Congress began laying the foundation for payment reform. In those acts, the Congress instructed the Secretary of Health and Human Services (HHS) to initiate development of two major components of a fee schedule that would accurately reflect the resource costs necessary to provide each service. The first component is a resource-based relative value scale, which would give each service a weight to indicate its value relative to any other service (mandated in the 1985 act).1/ The second component is a geographic index of practice costs, which could be used to adjust the relative value scale for differences in local costs (mandated in the 1986 act).2/ Initial versions of both a relative value scale (RVS) and of a geographic practice cost index (GPCI) are now available.

In the 1985 act, the Congress also established the Physician Payment Review Commission (PPRC), with a mandate to advise on payment reform under Medicare.

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1. See William C. Hsiao, Peter Braun, et al., "A National Study of Resource-Based Relative Value Scales for Physician Services: Final Report," Contract No. 17-C-98795/1-03, Health Care Financing Administration, U.S. Department of Health and Human Services, September 27, 1988.

2. See W.P. Welch, Stephen Zuckerman, and Gregory Pope, "The Geographic Medicare Economic Index: Alternative Approaches: Draft Report," Contracts No. 18-C-98326/1-01, 17-C-99222/3-01, 17-C-98758/1-03, Health Care Financing Administration, U.S. Department of Health and Human Services, May 1989.

In its April 1989 report, PPRC recommended adoption of a Medicare fee schedule based on a modified version of the RVS developed for the Health Care Financing Administration (HCFA), using one of the practice cost indexes also developed for HCFA.

The purpose of this memorandum is to compare the proposals for changing physician payment under Medicare that are emerging in the Congress, many of which are variations on the PPRC recommendations. In what follows, the first section summarizes PPRC's recommendations, both for payment reform and for transitional payment policies. The second section describes the payment reform proposals that have been approved this session by the House Committee on Ways and Means, the House Committee on Energy and Commerce, and the Senate Finance Committee. It also simulates the effects of these proposals by specialty, by geographic area, and by enrollee group. The third section examines the corresponding committee proposals that would be implemented for 1990.

The effects of alternative plans are estimated by simulating each payment proposal on Medicare claims for a representative sample of enrollees for 1986, after adjusting the data to reflect 1990 conditions. For those enrollees included in the sample, claims for all services (excluding anesthesiology) provided by physicians and by limited license practitioners were retained. Claims for services provided by medical suppliers were excluded. (See the technical appendix for a discussion of the data and simulation methods.)3/

RECOMMENDATIONS OF THE PHYSICIAN PAYMENT REVIEW COMMISSION

PPRC has recommended a four-part package to reform Medicare physician payment. This package includes:

- A Medicare fee schedule based on resource costs;
- Limits on balance-billing (billed amounts in excess of Medicare's approved payment rates for which the patient is liable);
- Annual expenditure targets to limit growth in costs; and
- Increased support for research intended to identify effective treatments and to develop acceptable practice guidelines.

PPRC has urged enactment this year of legislation that would replace the CPR system with a fee schedule for 1992, following a two-year transition period during which prevailing fees under the CPR system would be adjusted toward fee

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3. PPRC provided CBO with tapes of their 1986 beneficiary sample, along with the component values for the fee schedule proposed in their 1989 report.

schedule rates.4/

The Commission has also recommended that payment localities be redefined for 1992 and subsequent years. Currently, carriers define payment localities in a variety of ways which need not correspond to the boundaries of meaningful economic markets.

Each part of PPRC's four-part package is discussed in more detail below.5/

The Resource-Based Medicare Fee Schedule

The Medicare fee schedule (MFS) would have three basic components:

- A relative value scale (RVS), which would indicate the value of each service relative to others;
- A geographic practice cost index (GPCI), which would reflect cost differences across areas; and
- A monetary conversion factor (CF), which would translate the indexed relative values into a fee for each service.

The Relative Value Scale. The RVS for each service would include a measure of work (W) provided by physicians, plus a measure of physicians' practice expenses (E). Practice expenses include costs for office space, personnel, equipment, supplies, and malpractice insurance. In contrast to the RVS developed for HCFA, the modification developed by PPRC would have no specialty-specific components.

The PPRC has advised that there are a number of tasks yet to be completed before a full PPRC-approved RVS will be available. The current list of services and specialties for which reliable work values have been estimated must be expanded to all services and specialties; in the preliminary RVS now available, work values for many services were obtained by extrapolations whose validity is questionable. Refinements to PPRC's estimates of practice expenses must be made following analysis of new survey data. Both analytical and survey work will be necessary in order to determine the best treatment for malpractice insurance costs. Coding reform will be necessary for two categories of services: surgical services must be defined consistently by carriers to include pre- and post-operative care by the primary surgeon (a global fee); and evaluation and management (or visit) codes must be more precise, including time as part of the definition.

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4. See Statement of the Physician Payment Review Commission before the Committee on Finance, United States Senate, March 17, 1989; also see Physician Payment Review Commission, Annual Report to Congress, April 1989.

5. See Sandra Christensen and Scott Harrison, "Estimated Impact of PPRC's Proposed Medicare Fee Schedule, by Specialty and Geographic Area," Staff Memorandum, U.S. Congressional Budget Office (June 12, 1989), for simulation results.

The Geographic Index. Like the RVS, the GPCI has two components--one to adjust the work value (WGPCI), and one to adjust the practice expense value (EGPCI) in the RVS. PPRC recommends that only the practice expense component of the RVS be indexed for geographic variation in costs. In this instance, the amount physicians would receive for their time and effort (apart from practice expenses) would be invariant by locality for any given service.

The Conversion Factor. The conversion factor transforms an indexed RVS into a schedule of dollar payments for each service. It is a single nationwide value that can be set to achieve any given amount for aggregate payments to physicians under Medicare.

The above three components are combined to give fee schedule amounts. In general, the fee for service i in locality j would be:

$$MFS(i,j) = CF * [W(i)*WGPCI(j) + E(i)*EGPCI(j)].$$

Because the fee schedule recommended by PPRC would adjust only the expense component for local cost differences, however, it would become:

$$MFS(i,j) = CF * [W(i) + E(i)*EGPCI(j)].$$

This fee schedule would not be fully implemented under PPRC's recommendations until 1992, however. A transition toward budget-neutral fee schedule payments would begin in 1990 and continue for 1991. During the transition, Medicare's payments would be set by the CPR system, but prevailing charges would be moved part way toward fee schedule amounts in each locality.

For 1990, adjustments to prevailing charges would be made only for 300 to 500 common service codes, codes which account for at least 80 percent of Medicare's payments to physicians. In each locality, prevailing charges for these codes would first be updated by the MEI, and then adjusted by one-fifth of the percentage by which the average allowed amount (AAA) for the service in the locality differed from the estimated MFS payment for it. That is:

$$New\ PC(i,j,k) = PC(i,j,k) + .2*[MFS(i,j) - AAA(i,j)]$$

where k denotes the physician specialties for which each prevailing charge is defined.

For 1991, sufficiently reliable RVS values should be available to permit adjustment of prevailing charges for all service codes. For the services that received a prevailing charge adjustment for 1990, the 1991 adjustment would be:

$$New\ PC(i,j,k) = PC(i,j,k) + .25*[MFS(i,j) - AAA(i,j)].$$

For other services, which received no prevailing charge adjustment in 1990, the 1991 adjustment would be:

$$New\ PC(i,j,k) = PC(i,j,k) + .4*[MFS(i,j) - AAA(i,j)].$$

The result of this process is that prevailing charges for all services would be

adjusted by 40 percent of the distance from fee schedule amounts for 1991.6/

Limits on Balance-Billing

PPRC stops short of recommending mandatory assignment of physicians' bills--which would eliminate all balance-billing costs for Medicare enrollees. Instead, it recommends continuation of Medicare's participating physician program, and suggests that for nonparticipating physicians billed amounts be capped at a fixed percentage above fee schedule amounts.7/ No specific percentage was proposed by PPRC, although current MAAC (maximum allowable actual charge) limits would ultimately result in a cap on bills at 115 percent of prevailing charges. Under a fee schedule, any limit on billed amounts would be much simpler to determine than current MAACs, which are physician-specific and depend on the previous year's charges as well as the current year's prevailing fees.

In addition, PPRC advocates complete elimination of balance-billing for all enrollees who are also eligible for Medicaid benefits. This is already in law for enrollees eligible for full Medicaid benefits. The Medicare Catastrophic Coverage Act (MCCA) of 1988 extended limited Medicaid benefits to all poor Medicare enrollees by 1992, but did not explicitly extend the prohibition on balance-billing to this new group of "qualified Medicaid beneficiaries." PPRC advises clarification of the MCCA to ensure that even enrollees eligible only for limited Medicaid benefits are exempted from all balance-billing costs.

Expenditure Targets

PPRC recommends implementation of annual expenditure targets in order to give physicians collective incentives to contain costs. The goal is not only to control growth in costs, but also to induce the medical community to work with the Medicare program to increase knowledge of the efficacy of alternative services, thereby improving treatment practices.

The expenditure target recommended by PPRC would reflect increases in practice costs, growth in the number of Medicare enrollees, and some allowance for changes in the volume of services per enrollee to account for advances in technology. If growth in actual expenditures for physicians' services was equal to the target rate of growth, then the update to the conversion factor for the following year would equal the percentage by which practice costs increased nationwide. If actual expenditure growth was above the target, then the update would be lower than the percentage growth in practice costs by just enough to reflect the difference between actual and target growth rates. Similarly, if expenditure growth was below the target, the update would be higher than the percentage growth in practice costs.

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6. For the services adjusted both in 1990 and in 1991, the second year adjustment would close one-fourth of the distance between fee schedule amounts and average allowed amounts for 1991, which would be only 80 percent of the 1990 distance. Hence, only 60 percent of the original first-year distance would remain.

7. Participating physicians agree to "accept assignment" on all Medicare claims for a given period of time--which means that they bill Medicare directly, accept Medicare's payment rates, and collect only deductible and coinsurance amounts from patients. In return, their prevailing charges are 5 percent higher than those for nonparticipating physicians.

Initially, the expenditure target would be a single nationwide value. Over time, however, PPRC suggests that separate targets might be set by geographic area, by specialty, or by service categories.

Effectiveness Research and Practice Guidelines

PPRC recommends a substantial increase in federal support for research into the efficacy of alternative treatments and for dissemination of the findings. The incidence of unnecessary or inappropriate medical care could be reduced by this effort, if the resulting information was readily available to physicians and patients. In addition, this information could be used as the basis for decisions about coverage and for utilization review programs.

The federal role envisioned by PPRC in this area includes funding, coordination, and evaluation, largely of private initiatives by the medical profession and researchers. PPRC believes that federal oversight should focus on insuring the integrity of the process and on facilitating dissemination of information resulting from the research.

PAYMENT REFORM PROPOSALS

The House Committee on Ways and Means (W&M), the House Committee on Energy and Commerce (E&C), and the Senate Finance Committee (SFC) have each completed their recommendations for the reform of Medicare's physician payment system. The House proposals are included in its budget reconciliation bill for fiscal year 1990, but the Senate proposals are not. The first section below describes the proposals developed by these committees; the second section gives CBO's estimates of their effects.

Description of Reform Proposals

When fully implemented, the Ways and Means proposal for reforming Medicare's physician payment system would:

- Pay physicians according to a resource-based Medicare fee schedule (MFS);
- Adjust the MFS practice expense component--but not the physician work component--for geographic cost differences;
- Continue the participating physician program, paying nonparticipating physicians 5 percent less than participants;
- Pay a 5 percent bonus for primary care services in health manpower shortage areas;8/

8. Under current law (as enacted in the budget reconciliation act of 1987), a 5 percent bonus would be paid for all services in health manpower shortage areas by 1991.

- Cap nonparticipating physicians' actual charges at 115 percent of their MFS amounts;

- Establish a target rate of growth for physician spending under Medicare each year set by the Congress based on the recommendations of the Secretary of HHS and PPRC; if the Congress failed to specify a target in legislation, the default target would equal the sum of the percentage change in the consumer price index and the percentage change in Medicare enrollment;

- Update MFS amounts each year by the percentage increase in the appropriate cost index minus (or plus) the percentage by which actual expenditure growth exceeded (or fell short of) the target rate of growth for the previous year;9/

- Increase funding for medical effectiveness research.

W&M would implement a fee schedule--eliminating the CPR mechanism--on October 1, 1991. For the period through December 1992, an "historical payment basis" (HPB) would be calculated for each service in each locality as the average, regardless of specialty, of prevailing charges projected for that period, adjusted to reflect instances in which payment rates were below prevailing charges. Payment rates would be the lesser of the provider's actual charge or an HPB-constrained MFS amount. The constrained MFS amount could be no more than 15 percent higher or lower than the HPB.

For 1993 through 1995, payments would be the lesser of actual charges and constrained MFS amounts, which would have to be within 15 percent of the constrained MFS amounts for the previous year. Each year, a larger proportion of payments would be set by actual MFS amounts until, effective January 1, 1996, all payments would be the lesser of actual charges and unrestricted MFS amounts.

The Energy and Commerce proposal for payment reform, when fully implemented, would:

- Pay physicians according to a resource-based Medicare fee schedule (MFS);

- Adjust both work and practice expense components for geographic cost differences;

- Continue the participating physician program, paying nonparticipating physicians 5 percent less than participants;

- Cap nonparticipating physicians' actual charges at 120 percent of the MFS amounts applicable for participating physicians;

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9. For most physicians' services, the appropriate cost index would be the MEI. For some services, such as clinical laboratory procedures, the cost index would be the consumer price index.

- Update MFS amounts each year by an index--established by the Secretary of HHS--that would reflect the percentage change in the value of resources used to produce physicians' services, unless an alternative update was enacted by the Congress;

- Increase funding for medical effectiveness research.

E&C would begin a phase-in to the MFS on April 1, 1990. For 1990 and 1991, payments would be set by the CPR mechanism. In 1990, prevailing charges for about 400 procedures would be adjusted by 20 percent of the difference between existing prevailing charges and MFS amounts. For 1991, all services would be included, and prevailing charges would be adjusted by 25 percent of the remaining difference.

The CPR mechanism would be eliminated as of 1992. For 1992, payment would be the lesser of actual charges or an adjusted MFS amount, where the adjustment would be half of the remaining difference between MFS amounts and prevailing charges. For 1993 and subsequent years, payment would be set by the lesser of actual charges or unconstrained MFS amounts.

The Senate Finance Committee proposal for payment reform, when fully implemented, would:

- Pay physicians according to a resource-based Medicare fee schedule (MFS);

- Adjust the MFS practice expense component--but not the physician work component--for geographic cost differences;

- Continue the participating physician program, paying nonparticipating physicians 5 percent less than participants;

- Pay a 10 percent bonus for all physicians' services in health manpower shortage areas;

- Cap nonparticipating physicians' actual charges at 115 percent of the MFS amounts applicable for participating physicians;

- Establish a nonbinding volume performance standard against which to assess the percentage growth in spending for physicians' services; this standard would equal the sum of the percentage change in the MEI, the percentage change in Medicare enrollment, and the percentage change in volume of services per enrollee (averaged over the previous five-year period) reduced by 2 percentage points;

- Update MFS amounts each year by the percentage change in the MEI less 2 percentage points, unless an alternative update was enacted by the Congress;

- Increase funding for medical effectiveness research.

SFC would begin the transition to the MFS in 1991, when payment would equal the lesser of actual charges or the "adjusted prevailing charge." The adjusted prevailing charge (APC) for a given locality would be a weighted average, across all specialties, of prevailing charges adjusted to reflect instances in which payment rates were below prevailing charges.

For 1992 through 1995, payment would equal the lesser of actual charges or a blended amount based on the updated APC and the MFS. For 1992, the blend would be 80 percent APC and 20 percent MFS. In 1993, it would be 60 percent APC and 40 percent MFS. In 1994, it would be 40 percent APC and 60 percent MFS. In 1995, it would be 20 percent APC and 80 percent MFS, In 1996 and later years, the blend would be 100 percent MFS; payment would be the lesser of actual charges or the MFS amount.

These proposals share substantial common ground, both with each other and with PPRC's recommendations. The committees have each endorsed a fee schedule as the basis of payment for physicians' services under Medicare, to be implemented in a budget neutral fashion. They would each continue the participating physician program with its 5 percent payment differential. They would limit balance-billing by capping nonparticipating physicians' actual charges per service. Finally, each committee would authorize more spending on medical effectiveness research. All of these coincide with PPRC recommendations.

There are some differences between the proposals, however. One difference lies in the default provisions for updating MFS rates. Only W&M would follow PPRC's recommendation for an expenditure target. W&M would use the difference between actual and target growth in spending to automatically adjust the cost-based MFS update factor; the default target would include no allowance for increases in volume per enrollee. E&C did not include expenditure targets in its reform package and would update MFS rates based on the actual percentage change in practice costs. SFC would update MFS rates by the percentage change in the MEI less 2 percentage points. Under each proposal, however, Congress might enact an alternative to the default provisions.

Another difference between the proposals is in indexing for geographic differences in costs. Following PPRC's recommendation that the value of the physician work component be uniform nationwide for a given service, neither W&M nor SFC would adjust the work component of the MFS for geographic differences in costs, while E&C would. Specifically, the payment formula for the W&M and the SFC proposals is:

$$MFS(i,j) = CF * [W(i) + E(i)*EGPCI(j)]$$

while the formula for the E&C proposal is:

$$MFS(i,j) = CF * [W(i)*(1+WGPCI(j))/2 + E(i)*EGPCI(j)]$$

where ((1+WGPCI)/2) uses half of the earnings index differential to adjust the physician work component.

Finally, the proposals differ with respect to the balance-billing limitation. W&M would limit actual charges to 115 percent of the MFS amount applicable for nonparticipating physicians; E&C would limit actual charges to 120 percent of the MFS applicable for participating physicians; SFC would limit actual charges to 115 percent of the MFS applicable for participating physicians. Hence, W&M has the most stringent limit on balance-billing, while E&C has the least stringent limit.

Simulation Results

There are two aspects of the reform proposals that are not incorporated into the simulations reported here. For one, the data do not currently exist to separate malpractice insurance costs from physicians' other practice expenses, as PPRC and the committees have proposed doing once technical issues associated with this approach have been resolved. Second, the data used here do not permit us to identify health manpower shortage areas, where a bonus would be paid for some or all services. Hence any differences in effects between the proposals are due to differences in indexing for costs and in balance-billing limits.

The results shown are for fee schedules that would be budget neutral subsequent to projected behavioral responses by physicians and their patients. The first set shows impact or pre-behavior results, while the second set shows the effects of the payment proposals after estimated behavioral responses occur. Practices that would face lower Medicare receipts at impact would accelerate growth in their volume of services, thereby offsetting a portion of the initial revenue loss. On the other hand, practices that would gain at impact would slow growth in the volume of services, offsetting a portion of their initial gain.10/

Pre-Behavior Impact Results. This section discusses the initial or pre-behavior impacts of the reform proposals. For both options, conversion factors have been set to produce post-behavior budget neutrality. The overall reduction in allowed amounts at impact indicates the size of the downward adjustment to the MFS conversion factor that must be made to achieve budget-neutrality subsequent to behavioral responses.

On impact, allowed amounts would fall by 4.3 percent to 5.5 percent overall, while receipts would fall by 6.7 percent to 8.9 percent (Table 1). The largest fall in allowed amounts on impact would occur under the W&M proposal because it would impose the tightest limits on balance-billing, thereby inducing the largest volume response. Allowed amounts would fall the least, on impact, under the E&C proposal.

By Specialty. Each proposal would increase payments to medical specialties and reduce payments to surgical and supporting specialties. Medicare's allowed amounts for medical specialties would increase by 8.8 percent or more from current levels, while allowed amounts for surgical specialties would fall by 11.4 percent or more. Family practitioners would see the largest increases in both allowed amounts and receipts, with allowed amounts increasing by approximately 26 percent and

10. See the technical appendix for more discussion of the volume response.

receipts increasing more than 18 percent. Thoracic surgeons, radiologists, and pathologists would face the largest payment cuts, ranging from 18 percent to 25 percent.

By Geographic Area. Under each proposal, practices in rural areas would typically receive higher allowed amounts at impact, while urban areas would get less than under the current system (Table 2). The changes in allowed amounts relative to current law are larger, however, for the W&M and SFC proposals than for the E&C proposal. In part, this reflects the larger conversion factor adjustment required to achieve post-behavior budget neutrality under the W&M and SFC proposals, but it also reflects the indexing difference in the E&C proposal. Because the work component would be indexed only under the E&C proposal, there would be less equalization in payments between high-cost (typically urban) and low-cost (typically rural) areas, compared to the other proposals. In all rural areas, allowed amounts would be lower under the E&C proposal than under the other proposals. Urban areas as a whole tend to do better under the E&C proposal, although there are exceptions to this in specific regions.

By Enrollee Group. For enrollees who are neither poor nor Medicaid-eligible, out-of-pocket liabilities for physicians' services under Medicare will be an estimated $294 for 1990 under current law. Of that amount, $237 represents coinsurance and deductible amounts, while balance-billing costs account for the remaining $57 (Table 3).

Because of the caps they would impose on actual charges, the reform proposals examined here would reduce balance-billing costs by 48 percent to 68 percent overall, on impact--that is, balance-billing costs would be lower by $27 to $39 if the reforms were fully implemented for 1990. (Table 4).11/ Total enrollee liabilities would fall by 12 percent to 17 percent, or by $35 to $50. Overall, enrollees' costs would be lowest under the W&M package, and highest under the E&C package. Enrollees who reside in very large metropolitan areas and those hospitalized during the year would see the biggest drop in their out-of-pocket liabilities.

Final (post-behavior) effects. The results discussed here are "steady-state" (post-behavior) effects from a fully-implemented, budget-neutral fee schedule. These results are more uncertain than the results presented in the last section, because they are based on estimated behavioral parameters.

The effect of the behavioral responses incorporated into these results is generally to dampen the initial impact of any payment change. Overall, allowed amounts would be unchanged (compared to a pre-behavior decrease of about 5 percent), and receipts would decrease by about 3 percent (compared to a pre-

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11. Estimated effects on balance-billing costs may be overstated because of two assumptions implicit in the simulations. First, it was assumed that current assignment patterns would be unchanged by payment changes, although in fact assignment rates might fall among physicians whose payment rates drop (and increase among physicians whose rates rise). Second, it was assumed that physicians' billed amounts would be unchanged by payment changes in all instances but one--billed amounts were assumed to increase to MFS amounts if they were initially less. Because MAAC limits might also increase, though, billed amounts might increase even when they already exceed MFS amounts.

behavior decrease of 7 percent to 9 percent).

By specialty. The post-behavior effects of the reform proposals are similar in direction to the pre-behavior impacts, although they are smaller. Under the proposals, allowed amounts to medical specialists would increase by about 8 percent and allowed amounts to surgical specialists would fall by about 4 percent (Table 5). The simulations indicate an ultimate gain of 3 percent to 4 percent in receipts for medical specialists, and a decline of 6 percent to 7 percent for surgical specialists. The specialties who would face the largest payment cuts are thoracic surgery and radiology, while family practitioners would gain the most.

By Geographic Area. Overall, physicians' allowed amounts and receipts would increase in rural areas and would fall in urban areas under each proposal (Table 6). Because of the volume responses, the final effects are generally more favorable (or less unfavorable) than the initial impact of the payment reform packages.

Allowed amounts for physicians in rural areas in all of the census divisions are higher under the W&M and SFC proposals than under the E&C package. While physicians in urban areas as a whole would do better under the E&C proposal, urban physicians in five of the census divisions would receive higher allowed amounts under the other packages. This suggests that practices benefitting from the inclusion of a geographic index on the work component of the MFS are concentrated in urban areas in four census divisions--New England, Mid-Atlantic, East North Central, and Pacific.

Overall, physicians' receipts would be higher under the E&C proposal, with its less restrictive limits on balance-billing; but receipts would be higher under one of the other plans for rural areas in all census divisions. In three of the census divisions--West North Central, East South Central, and West South Central--practices in urban areas would also enjoy higher receipts under one of the other packages.

By Enrollee Group. The post-behavior effects by enrollee group are qualitatively similar to those found for the pre-behavior impacts, although reductions in enrollees' costs are smaller (Table 7). Overall, enrollees' costs would be 8 percent to 12 percent lower--a change of $24 to $35--relative to current law.

PAYMENT PROPOSALS FOR 1990

This section describes the physician payment provisions for 1990 contained in each committee's reconciliation package (as passed by House or Senate) and simulates the impact of some of these provisions. In some instances, these 1990 provisions are intended to begin a transition to a Medicare fee schedule.

Description of Proposals

Ways and Means Proposal. The W&M reconciliation provisions discussed here would cut Medicare payments for physician services by $995 million for fiscal year 1990 (Table 8). Some of the provisions would also realign payment rates so that

they would be closer to relative rates under an MFS. The physician payment provisions and their effects on relative payments are described below.

Reduce Prevailing Charges for Certain Overpriced Procedures. The committee's reconciliation proposals would reduce payments for procedures that appear to be overpriced relative to payments that would be made under a budget-neutral MFS. PPRC estimated payment levels for groups of procedures with RVS values thought to be reliable. A procedure was considered overpriced if the MFS payment would have been less than 85% of the national average Medicare allowed amount. Twenty-six procedure groups, containing about 200 specific procedure codes, would be cut under this provision. The cuts would be made as follows:

- The national average prevailing charge would be reduced by the percentage by which it exceeds the estimated national average MFS amount.

- The reduced national average prevailing charge would be adjusted by the practice expense component of the geographic practice cost index (EGPCI) to produce a target rate in each payment locality.12/

- The prevailing charge in each locality would be cut by half the distance to the target rate, subject to a maximum cut of 15 percent.13/ If the prevailing charge was below the target, there would be no rate adjustment under this provision.

Thus, prevailing charges for these procedures would move closer to estimated MFS in localities where they currently exceed those rates.

Reduce the Prevailing Charge Update for Nonprimary Care. For nonprimary care services only, the W&M package would reduce the MEI update that would otherwise take place. For all services, the MEI update would be effective April 1, 1990--three months later than it would otherwise occur. Under this provision, prevailing charges for primary care services would be increased by the full amount of the MEI (5.3 percent under current projections), but the increase for nonprimary care services would be limited to 2 percent. The higher update for primary care services would tend to move payments toward MFS rates, because current payments for primary care would be increased relative to other services under an MFS.

Reduce and Restructure Payments for Radiology Services. The W&M package would cut payments for radiology services and reallocate payments by locality based on a cost index. Since April 1, 1989, Medicare has paid radiologists under a locality-specific fee schedule. The fee schedule has nationally uniform

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12. The average share of the estimated MFS payment attributed to practice expenses is 46 percent. Thus the formula for adjusting the rate for each locality would be:

    Adjusted rate = Unadjusted rate * (.54 + .46*EGPCI(j)).

13. In designating certain overpriced procedures, PPRC advised that prevailing charges for 1990 should be moved no more than a third of the distance toward MFS-based target rates. The Commission was concerned that present data are not sufficiently accurate to permit larger adjustments without risk of overadjustment.

relative values for different radiology services, with locality-specific monetary conversion factors designed to maintain historical differences in aggregate payments by locality. This provision would reduce the average conversion factor by 8 percent and would vary payments across localities based only on differences in practice costs.

New cost-based conversion factors would be established as follows:

- o A national average conversion factor would be calculated and then reduced by 8 percent.
- o The reduced conversion factor would be adjusted by the EGPCI to produce a target conversion factor for each locality.
- o The current conversion factor in each locality would be reduced to its target, subject to a maximum cut of 15 percent. If the conversion factor was already below the target, it would be unchanged by this provision.

This provision would also tend to move relative payments closer to those under a fee schedule. As the simulations presented in the preceding section show, the MFS would reduce payment rates for radiology services by more than 20 percent, and would redistribute payments across localities based on costs.

Pay Actual Time for Anesthesiology Services. Currently, Medicare's prevailing charges for anesthesiology services are based on a relative value scale, although payment is still set by the CPR mechanism. The current method of setting the prevailing charge is as follows:

- o Each anesthesiology procedure has a set number of "base" units assigned to it, reflecting the relative complexity of the service.
- o A "time" unit is allowed for every 15 minutes of elapsed time that the anesthesiologist spends attending the patient. The time units are rounded up so that, for example, 16 minutes of elapsed time would allow the anesthesiologist to charge for two time units.
- o The base units and the time units are added, and their total is multiplied by a locality-specific conversion factor to arrive at the prevailing charge.

This proposal would change the time units allowed--from one unit for every 15 minutes or portion thereof, to 1/15 of a unit for every minute, effective April 1, 1990. This provision would result in a decrease in payments for anesthesiology services of about 3.3 percent. Preliminary findings indicate that the decrease in payments for anesthesiology services under the MFS would be greater than the cut under this provision, so that the provision would tend to move payments closer to what they would be under an MFS. Because current data on anesthesiology services are unsuitable for simulation, all anesthesiology services have been eliminated from the simulations.14/

14. We hope to be able to include anesthesiology services in future work.

Limit Prevailing Charges to Those of the Designated Specialty. This provision would limit the prevailing charges for all specialties providing a given service to the locality-specific prevailing charge for the specialty most likely to provide that service nationwide. This provision would affect only certain high-volume services selected by the Secretary of HHS. It cannot be included in the simulations until the procedures are selected and a specialty is designated for each one.

Limit the Customary Charges of New Physicians. Currently, new physicians not practicing in rural health manpower shortage areas have their customary charges for nonprimary services set to 80 percent of the applicable prevailing charge.15/ In subsequent years, their customary charges are calculated in the usual way, using each physician's own charge history. This provision would limit the customary charge to 85 percent of the prevailing charge during a new physician's second year, to 90 percent in the third year, to 95 percent in the fourth year, with no limit thereafter. Because all physicians in an area, regardless of years of experience, would be paid the same amount under an MFS, this provision would be inconsistent with an MFS. The provision was not incorporated into the simulations because new physicians cannot be identified in the data.

Reduce Payments for Clinical Laboratory Procedures. The W&M reconciliation package contains two other physician payment provisions, not included in the simulations, that would affect payments for clinical laboratory services, effective January 1, 1990: one would provide a 2 percent update in the fee schedule (instead of the 4.7 percent update that would otherwise occur); the other would limit payments to 95 percent of the national median fee for each laboratory service.

Energy and Commerce Proposal. Under the E&C reconciliation provisions described here, payments for physicians' services would be cut by $767 million in fiscal year 1990 (Table 8). Several provisions in the package would have some potential for moving current payment rates toward MFS rates. All of the physician payment reconciliation provisions are discussed below, although not all of them can be included in the simulations at this time.

Adjust Prevailing Charges as MFS Transition Step. As of April 1, 1990, prevailing charges for about 400 service codes would be moved toward MFS values.16/ New prevailing charges for these services would be calculated as follows:

- Target MFS amounts would be calculated, with the conversion factor being set so Medicare would pay the same aggregate amount for these services as it would have paid in the absence of this adjustment to prevailing charges.

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15. In other cases, customary charges for new physicians are set at the median of customary charges for other physicians in the locality, which may exceed the prevailing charge.

16. This list of codes was provided by PPRC. It includes about 100 codes which are considered to be E&M services (including all primary care services). The list also includes another approximately 300 service codes for which PPRC has reasonable confidence in the cost-based relative values. These codes were either for procedures that were surveyed for HCFA, or for procedures in the same family as ones that were surveyed.

- Prevailing charges for the approximately 100 codes classified as evaluation and management (E&M) services would all be increased by the same amount, equal to the amount that total payments for the group would have increased under the MFS.17/

- Prevailing charges for the remaining 300 codes would be moved 20 percent of the distance, up or down, toward the target values.

Eliminate the Prevailing Charge Update. There would be no update to prevailing charges for 1990 for any services. This contrasts with the W&M and SFC proposals, which would update prevailing charges for primary care services by the full MEI and would provide a reduced update of 2 percent for other services. The E&C freeze, when combined with the transition provision above, would have effects similar to those for the update provisions in the other two packages. This is because all primary care services are in the E&M group whose rates would increase by an estimated 4.3 percent under E&C's transition provisions.

Restructure Payments for Radiology Services. The conversion factors currently used in the radiology fee schedule would be adjusted to reflect differences in practice costs across localities, regardless of historical price differences. This provision differs from the W&M proposal in four ways: there would be no reduction in the average conversion factor; specialists in nuclear medicine and nonradiologists would be unaffected; both work and expense components would be adjusted for geographic differences in costs; and conversion factors would be set equal to the target factors regardless of the size or direction of the necessary adjustment.

Pay Actual Time for Anesthesiology Services. This provision is identical to the W&M provision described previously, except that the effective date is Jan. 1, 1990.

Implement a Fee Schedule for Pathology Services. HCFA, under a Congressional mandate, has developed a charge-based fee schedule for pathology services. This provision would implement that fee schedule in a budget-neutral fashion, effective January 1, 1990. The RVS for each procedure would be multiplied by a geographic cost index and a conversion factor designed to achieve nationwide budget-neutrality.18/ Medicare would reimburse 80 percent of the lesser of the fee schedule amount or the physician's actual charge. Because the RVS for pathology has not been published, CBO cannot yet simulate the effects of this provision.

Reduce Payments for Clinical Laboratory Services. While the E&C package contains the same provision to limit payments under the clinical laboratory fee schedule to 95 percent of the median fee, it differs from the W&M package by

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17. E&M services are treated as a group because there is little confidence in the values for individual E&M codes. There is considerable variation among physicians in their use of the specific codes. Prior to final implementation of the MFS, E&M codes would be redefined, making clearer distinctions between them.

18. The cost index used under the proposal would be $(W(i)*(1+WGPCI(j))/2)+(E(i)*EGPCI(j))$.

allowing the full update on the fee schedule for laboratory services. This is not included in the simulations.

Senate Finance Committee Proposal. The SFC reconciliation provisions described here would reduce Medicare payments for physicians' services by $800 million for fiscal year 1990 (Table 8). Because the SFC provisions are either identical or similar to House provisions, the description here is abbreviated.19/

Reduce Prevailing Charges for Certain Overpriced Procedures. This provision would be take effect April 1, 1990, and would be identical to the W&M proposal with one exception. Prevailing charges would be cut by one-fourth of the distance between current prevailing charges and target rates, not to exceed 15 percent. (W&M would cut by half the distance, subject to the same 15 percent limit.)

Reduce the Prevailing Charge Update for Nonprimary Care. This provision is identical to that proposed by W&M. The update to prevailing charges would be delayed until April 1, 1990. At that time, primary care services would receive the full MEI update (5.3 percent), while other services would get a 2 percent update.

Reduce Payments for Radiology Services. Under the SFC proposal, the radiology fee schedule conversion factors (or prevailing charges, for services not set by fee schedule) would be reduced by 2 percent in each locality, effective April 1, 1990. Specialists in nuclear medicine would be exempted, however. The SFC provision would not restructure rates based on geographic cost differences, as both the W&M and the E&C proposals would. The cut in payment for radiologists would be larger than under the E&C proposal (where there would be no cut, on average); but smaller than under the W&M proposal (where there would be an 8 percent cut, on average).

Pay Actual Time for Anesthesiology Services. This provision is identical to the W&M provision. Anesthesiologists would be paid for each minute of time spent with a patient, rather than for each 15-minute segment or portion thereof, effective April 1, 1990.

Reduce Payments for Clinical Laboratory Services. The SFC package includes nearly identical provisions for clinical laboratory services as are in the W&M package. Instead of a full update in the laboratory fee schedule, only a 3 percent update would be given, effective April 1, 1990 (compared to a 2 percent update effective January 1 in the W&M package). As in the W&M package, payments would be limited to 95 percent of the national medican fee for each laboratory service.

Simulation results

The estimated impacts and final effects of selected provisions for 1990 are presented in this section. For each of the reconciliation packages, the simulations

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19. The proposals examined here are those included in the budget reconcilation bill passed by the Senate; they differ in some respects from those originally reported out of the Senate Finance Committee.

incorporate three provisions. For the W&M and SFC packages, the simulations include the reduction in prevailing charges for overpriced procedures, the reduction of the MEI update for nonprimary care services, and the reduction and the reallocation (for W&M only) of payments for radiology services. For the E&C package, the simulations include the transition toward MFS rates for selected services, the MEI freeze, and the payment reallocation for radiology services. Data limitations prevented inclusion of the other provisions. For comparability, the simulations show effects for a full year.

Impact (Pre-behavior) Results. The results discussed in this section show the initial impact of the packages examined, prior to behavioral responses. Under the W&M proposal, allowed amounts would fall by 5.6 percent overall, and receipts would fall by 4.9 percent from current levels. Under the E&C package, allowed amounts would fall by 4.5 percent, while receipts would fall by 3.6 percent. Under the SFC package, allowed amounts would fall by 4.5 percent and receipts would fall by 4 percent. The overall decline in payments under the E&C package is entirely the result of the MEI freeze, while all of the provisions contribute to the drop in payments under the W&M and SFC packages.

By Specialty. The reduction in allowed amounts to medical specialties would range from 2.6 percent under both the E&C and SFC proposals to 3 percent under the W&M proposal (Table 9). Allowed amounts to surgical specialties would be reduced by 5.9 percent to 7.1 percent. The impacts by specialty vary the most under the W&M package, and least under the E&C proposal. Under the W&M provisions, both thoracic surgeons and radiologists would face cuts of nearly 11 percent in allowed amounts at impact. The largest drop in allowed amounts under the E&C proposal would be about 8 percent, for thoracic surgeons. The greater variability under the W&M proposal (and, to a lesser extent, under the SFC proposal) is due to the more narrowly focussed reductions, under which radiologists and specialists performing certain overpriced procedures would absorb a greater share of the reductions.

By Geographic Area. The impacts of the proposals across geographic areas would be similar and fairly uniform, even when comparing urban and rural areas (Table 10). Physicians in the West South Central division would face the largest cuts under each package. The larger overall cuts under the W&M provisions would be so evenly distributed that only in rural New England would the cut under the E&C package be more.

By Enrollee Group. Each package would increase balance-billing costs for enrollees, but would lower their total liabilities at impact (Table 11). Balance-billing would increase because some of the charges that were paid by Medicare would become the responsibility of enrollees if allowed amounts were reduced. The drop in total liabilities would occur because coinsurance costs would fall along with allowed amounts. Compared to the E&C package, the W&M and SFC provisions would reduce total liabilities by more, with smaller increases in balance-billing. Under each proposal, patient liabilities would decline more in more urban areas.

Final (post-behavior) results. Differences between the proposals would generally be reduced by behavioral changes, as shown in the post-behavior results discussed in this section. The W&M provisions would generate final reductions of 2.8 percent

in allowed amounts, not much different from the reductions of 2.5 percent under the E&C proposal and of 2.3 percent under the SFC package (Table 12).

By Specialty. Allowed amounts for medical specialties would fall by about 1.4 percent to 1.6 percent, while payments would fall by 3 percent to 3.6 percent for surgical specialties. Because of the 8 percent cut targeted on radiologists under the W&M proposal, the reduction in payments to radiologists would be twice as large as it would be under the E&C proposal (which has no cut for radiologists, on average, apart from the MEI freeze). The effect of the SFC proposal for a 2 percent reduction for radiologists would fall between the effects of the other two proposals. Under each proposal, thoracic surgeons would also face relatively large cuts.

By Geographic Area. After behavioral responses, the effects by area would be even more uniform than they were for the pre-behavior impacts (Table 13). Physicians' allowed amounts and receipts would fall by more under the W&M package than under the other proposals, although the differences are small.

By Enrollee Group. The fall in enrollees' liabilities that would occur on impact would be completely offset for most enrollee groups by volume increases (Table 14). In fact, under the E&C provisions total liabilities would be higher than under current law. Balance-billing costs and total liabilities would be lower under the W&M and SFC proposals than under the E&C provisions for all enrollee groups.

TECHNICAL APPENDIX

The estimates shown in this memorandum were derived from simulations on Medicare claims for a representative sample of nearly 83,000 enrollees (a BMAD III beneficiary file, first compiled by PPRC). For enrollees in the sample, all physicians' claims filed on their behalf during calendar year 1986 were included, excluding claims filed for anesthesiology services.20/

The data were adjusted to reflect CBO's 1990 projections for participation rates, assignment rates, Medicare's customary and prevailing fees, and physicians' submitted charges. Allowed amounts for 1990 were then calculated using the CPR methodology, choosing the lesser of the customary, the prevailing, or the actual charge for each claim. In the adjusted data, about 60 percent of allowed amounts were for participating physicians, and about 20 percent of allowed amounts were unassigned.21/

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20. Problems in interpreting anesthesiology claims prevent including them in the simulations at this time.

21. On unassigned claims, physicians' bill their patients, who are liable for the entire billed amount. Patients then may apply to Medicare for reimbursement of 80 percent of allowed amounts. On assigned claims, physicians bill Medicare directly, and patients are liable only for the difference between Medicare's reimbursement and Medicare's allowed amounts.

The impact of a given proposal for 1990 was simulated by changing prevailing fees as specified in the proposal, and by limiting billed amounts if new billing limits were a part of the proposal. The CPR methodology was then used to calculate new allowed amounts under the proposal, for comparison to baseline amounts. The change in physicians' receipts--which is the sum of changes in allowed amounts and in balance-billing under the proposal--was also calculated, for use in estimation of behavioral responses.

The initial impact of a proposal is the estimated change in allowed amounts and in receipts before any induced behavioral changes, reflecting only the change in payment rates. The final effect of a proposal incorporates estimated behavioral responses to the initial change in receipts. These behavioral responses partially offset the initial changes in receipts, but could offset or augment initial changes in allowed amounts for each practice.

The behavioral responses were estimated as elasticities that indicate the percent change in volume (measured as allowed amounts) in response to a given percent change in practice receipts. For losing practices, where the initial impact on receipts is negative, the estimated volume elasticity is -0.555. The volume elasticity is -0.375 for gaining practices, where the initial impact is positive.22/

The impact of a given fee schedule reform proposal was obtained in a similar way. Proposed fee schedule amounts were compared to baseline allowed amounts in the simulation. Initial impacts were modified by incorporating behavioral responses, using the volume elasticities given above.

In the fee schedule reform simulations reported here, Medicare's current payment localities were retained. The proposals call for a redefinition of payment localities sometime after 1990, however, perhaps to correspond more closely to the payment areas defined by Metropolitan Statistical Areas used for Medicare's hospital payments. Data do not permit this redefinition at this time.

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22. Derivation of these estimates is discussed in Sandra Christensen, "Volume Responses to Exogenous Changes in Medicare's Payment Rates," Technical Memorandum, U.S. Congressional Budget Office (August 1989).

TABLE 1. PERCENT CHANGE IN ALLOWED AMOUNTS AND MEDICARE RECEIPTS UNDER REFORM PROPOSALS, BY SPECIALTY PRE-BEHAVIOR IMPACT

Specialty	WAYS AND MEANS		ENERGY AND COMMERCE		SENATE FINANCE	
	Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts
All Specialties	-5.5%	-8.9%	-4.3%	-6.7%	-4.9%	-7.8%
Medical Specialties	8.8%	4.1%	10.0%	6.3%	9.5%	5.3%
Internal Medicine	5.6%	1.3%	7.2%	3.8%	6.3%	2.5%
Family Practice	25.8%	18.8%	25.6%	19.5%	26.6%	20.0%
Dermatology	-2.9%	-6.0%	-1.3%	-3.5%	-2.3%	-4.9%
Surgical Specialties	-12.4%	-15.6%	-11.4%	-13.4%	-11.8%	-14.3%
Opthalmology	-15.9%	-17.3%	-14.9%	-15.1%	-15.3%	-16.1%
General Surgery	-11.9%	-15.9%	-11.2%	-13.9%	-11.3%	-14.7%
Orthopedic Surgery	-9.1%	-13.5%	-8.2%	-11.1%	-8.5%	-12.1%
Urology	-7.0%	-11.7%	-6.0%	-8.9%	-6.3%	-10.1%
Thoracic Surgery	-22.6%	-24.7%	-21.6%	-22.6%	-22.1%	-23.6%
Otolaryngology	4.0%	-2.0%	5.5%	0.6%	4.7%	-0.7%
Gynecology	-2.4%	-10.7%	-1.1%	-8.2%	-1.8%	-9.4%
Supporting Specialties	-22.2%	-23.3%	-21.5%	-21.6%	-21.7%	-22.3%
Radiology	-22.8%	-23.3%	-22.0%	-21.5%	-22.3%	-22.2%
Pathology	-18.2%	-23.7%	-17.7%	-22.1%	-17.6%	-22.6%
Other Specialties	-3.3%	-6.9%	-1.9%	-4.6%	-2.8%	-5.8%

Source: Congressional Budget Office simulations from PPRC's 1986 BMAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

Note: See Table 5 for final effects, subsequent to behavioral responses.

TABLE 2. PERCENT CHANGE IN ALLOWED AMOUNTS AND MEDICARE RECEIPTS UNDER REFORM PROPOSALS, BY GEOGRAPHIC AREA
PRE-BEHAVIOR IMPACT

Region		WAYS AND MEANS		ENERGY AND COMMERCE		SENATE FINANCE	
		Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts
Nationwide	Total	-5.5%	-8.9%	-4.3%	-6.7%	-4.9%	-7.8%
	Urban	-6.9%	-10.1%	-5.2%	-7.4%	-6.3%	-9.0%
	Rural	4.8%	-0.6%	1.9%	-2.0%	5.5%	0.8%
New England (CT,MA,ME, NH,RI,VT)	Total	-2.7%	-4.1%	-2.3%	-3.3%	-2.1%	-3.2%
	Urban	-3.4%	-4.6%	-2.5%	-3.4%	-2.8%	-3.8%
	Rural	5.8%	2.7%	-0.1%	-2.1%	6.5%	3.7%
Mid-Atlantic (NJ,NY,PA)	Total	-7.7%	-10.4%	-4.4%	-6.5%	-7.1%	-9.4%
	Urban	-8.5%	-11.2%	-5.0%	-7.1%	-7.9%	-10.2%
	Rural	6.6%	4.2%	5.3%	3.6%	7.3%	5.2%
East North Central (OH,IL,IN, MI,WI)	Total	-0.1%	-4.1%	1.9%	-1.0%	0.5%	-2.9%
	Urban	-0.6%	-4.5%	1.8%	-1.0%	-0.0%	-3.2%
	Rural	6.1%	-0.3%	3.7%	-0.9%	6.7%	1.1%
West North Central (IA,KS,MN,MO, NE,ND,SD)	Total	2.9%	-1.9%	0.9%	-2.4%	3.6%	-0.5%
	Urban	-0.4%	-4.3%	-1.7%	-4.3%	0.2%	-3.1%
	Rural	14.2%	6.2%	9.7%	3.9%	15.0%	7.8%
South Atlantic (DE,DC,FL,GA,MD, NC,SC,VA,WV)	Total	-6.6%	-9.8%	-6.8%	-9.0%	-6.0%	-8.7%
	Urban	-9.4%	-12.4%	-9.0%	-10.9%	-8.8%	-11.3%
	Rural	6.1%	1.8%	2.8%	-0.2%	6.7%	2.9%
East South Central (AL,KY,MS,TN)	Total	2.2%	-2.0%	-0.3%	-3.2%	2.9%	-0.8%
	Urban	-1.2%	-5.2%	-3.4%	-6.1%	-0.5%	-4.0%
	Rural	13.5%	8.8%	10.3%	7.0%	14.3%	10.1%
West South Central (AS,LA,OK,TX)	Total	-8.5%	-13.4%	-9.8%	-13.1%	-8.0%	-12.1%
	Urban	-9.4%	-14.0%	-10.2%	-13.3%	-8.9%	-12.8%
	Rural	-6.4%	-11.9%	-9.0%	-12.8%	-5.8%	-10.6%
Mountain (AZ,CO,ID,MT, NV,NM,UT,WY)	Total	-2.2%	-7.4%	-1.7%	-5.4%	-1.5%	-6.0%
	Urban	-3.3%	-7.8%	-2.3%	-5.5%	-2.7%	-6.5%
	Rural	3.3%	-5.2%	1.1%	-4.9%	3.9%	-3.5%
Pacific (AK,CA,HI, OR,WA)	Total	-12.9%	-15.5%	-9.5%	-11.1%	-12.3%	-14.3%
	Urban	-13.1%	-15.7%	-9.6%	-11.2%	-12.5%	-14.5%
	Rural	6.4%	0.9%	4.9%	1.2%	7.1%	2.4%

Source: Congressional Budget Office simulations from PPRC's 1986 BMAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

Note: See Table 6 for final effects, subsequent to behavioral responses.

TABLE 3. BALANCE BILLING, COINSURANCE, AND TOTAL ENROLLEE LIABLITY UNDER CURRENT LAW, BY ENROLLEE GROUP
(In dollars per enrollee)

	Balance Billing	Coinsurance	Total Liability
All Enrollees	57	237	294
Residence			
Very large metro /a/	70	307	377
Large metro /b/	55	260	315
Other metro	58	227	285
Large rural /c/	53	209	262
Other rural	53	196	249
Income as Percent of Poverty Level			
100% - 149%	49	214	263
150% - 199%	51	221	272
200% - 299%	56	237	293
300% or more	64	247	311
Hospitalized			
Yes	150	520	670
No	28	151	179
Age			
Less than 65	49	254	304
65 - 74	57	223	280
75 - 84	59	253	312
85 or more	54	243	297

Source: Congressional Budget Office simulations from PPRC's 1986 BMAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

Note: Poor enrollees and Medicaid beneficiaries are excluded because their copayment and balance-billing costs would be eliminated under the proposals.

a. Population of 5 million or more.
b. Population of 1 to 5 million.
c. Non-metropolitan counties with population of 25,000 or more.

TABLE 4. PERCENT CHANGE IN BALANCE BILLING AND TOTAL ENROLLEE LIABILITY UNDER REFORM PROPOSALS, BY ENROLLEE GROUP
PRE-BEHAVIOR IMPACT

	WAYS AND MEANS		ENERGY AND COMMERCE		SENATE FINANCE	
	Balance Billing	Total Liability	Balance Billing	Total Liability	Balance Billing	Total Liability
All Enrollees	-67.6%	-16.5%	-47.7%	-12.0%	-56.6%	-14.1%
Residence						
Very large metro /a/	-70.3%	-22.9%	-52.7%	-16.3%	-59.9%	-20.7%
Large metro /b/	-67.1%	-16.1%	-47.6%	-11.2%	-56.1%	-13.8%
Other metro	-67.2%	-16.4%	-46.7%	-12.1%	-56.1%	-13.8%
Large rural /c/	-68.0%	-14.8%	-47.6%	-11.2%	-57.1%	-12.3%
Other rural	-67.4%	-14.3%	-46.5%	-10.9%	-56.4%	-11.7%
Income as Percent of Poverty Level						
100% - 149%	-66.9%	-14.5%	-46.4%	-10.3%	-55.7%	-12.1%
150% - 199%	-66.5%	-14.6%	-45.9%	-10.2%	-55.3%	-12.1%
200% - 299%	-67.2%	-15.9%	-47.3%	-11.4%	-56.1%	-13.4%
300% or more	-67.5%	-18.5%	-47.4%	-13.5%	-56.4%	-15.9%
Hospitalized						
Yes	-68.5%	-20.7%	-48.4%	-15.5%	-57.6%	-17.9%
No	-66.1%	-11.8%	-46.5%	-8.1%	-55.1%	-9.8%
Age						
Less than 65	-71.8%	-15.2%	-54.6%	-11.8%	62.5%	-13.3%
65 - 74	-67.9%	-17.5%	-48.0%	-12.8%	-57.0%	-15.0%
75 - 84	-66.1%	-16.2%	-45.5%	-11.5%	-54.7%	-13.7%
85 or more	-67.3%	-13.7%	-47.3%	-9.2%	-56.2%	-11.3%

Source: Congressional Budget Office simulations from PPRC's 1986 BMAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

Note: See Table 7 for final effects, subsequent to behavioral responses. Poor enrollees and Medicaid beneficiaries are excluded because their copayment and balance-billing costs would be eliminated under the proposals.

a. Population of 5 million or more.
b. Population of 1 to 5 million.
c. Non-metropolitan counties with population of 25,000 or more.

TABLE 5. PERCENT CHANGE IN ALLOWED AMOUNTS AND MEDICARE RECEIPTS UNDER REFORM PROPOSALS, BY SPECIALTY
POST-BEHAVIOR EFFECT

Specialty	WAYS AND MEANS		ENERGY AND COMMERCE		SENATE FINANCE	
	Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts
All Specialties	0.0%	-3.4%	0.0%	-2.4%	0.0%	-2.9%
Medical Specialties	7.6%	3.0%	7.8%	4.0%	7.8%	3.6%
Internal Medicine	5.6%	1.3%	5.9%	2.6%	5.7%	2.0%
Family Practice	18.0%	11.1%	17.3%	11.3%	18.4%	11.8%
Dermatology	1.4%	-1.8%	1.7%	-0.6%	1.5%	-1.2%
Surgical Specialties	-3.7%	-6.8%	-3.9%	-5.8%	-3.8%	-6.2%
Opthalmology	-6.3%	-7.7%	-6.4%	-6.7%	-6.4%	-7.2%
General Surgery	-3.1%	-7.0%	-3.4%	-6.1%	-3.2%	-6.4%
Orthopedic Surgery	-1.6%	-5.9%	-2.0%	-4.8%	-1.8%	-5.3%
Urology	-0.4%	-5.0%	-0.9%	-3.8%	-0.6%	-4.3%
Thoracic Surgery	-8.9%	-10.9%	-9.0%	-9.9%	-8.9%	-10.4%
Otolaryngology	6.0%	0.1%	6.1%	1.4%	6.0%	0.8%
Gynecology	3.5%	-4.3%	3.5%	-3.1%	3.4%	-3.7%
Supporting Specialties	-9.2%	-10.3%	-9.4%	-9.6%	-9.3%	-9.9%
Radiology	-9.8%	-10.3%	-10.0%	-9.5%	-9.9%	-9.9%
Pathology	-4.9%	-10.3%	-5.2%	-9.6%	-4.9%	-9.8%
Other Specialties	1.2%	-2.3%	1.4%	-1.2%	1.2%	-1.8%

Source: Congressional Budget Office simulations from PPRC's 1986 BMAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

TABLE 6. PERCENT CHANGE IN ALLOWED AMOUNTS AND MEDICARE RECEIPTS UNDER REFORM PROPOSALS, BY GEOGRAPHIC AREA POST-BEHAVIOR EFFECT

Region		WAYS AND MEANS		ENERGY AND COMMERCE		SENATE FINANCE	
		Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts
Nationwide	Total	0.0%	-3.4%	0.0%	-2.4%	0.0%	-2.9%
	Urban	-0.9%	-4.1%	-0.6%	-2.8%	-0.9%	-3.5%
	Rural	6.5%	1.1%	4.2%	0.4%	6.6%	1.8%
New England (CT,MA,ME, NH,RI,VT)	Total	0.3%	-1.1%	0.2%	-0.7%	0.5%	-0.7%
	Urban	-0.2%	-1.4%	0.1%	-0.8%	0.0%	-1.0%
	Rural	5.9%	2.8%	2.2%	0.2%	6.1%	3.4%
Mid-Atlantic (NJ,NY,PA)	Total	-1.6%	-4.2%	-0.3%	-2.4%	-1.5%	-3.8%
	Urban	-2.0%	-4.7%	-0.7%	-2.7%	-2.0%	-4.2%
	Rural	6.1%	3.7%	5.0%	3.3%	6.3%	4.2%
East North Central (OH,IL,IN, MI,WI)	Total	2.9%	-1.0%	3.3%	0.5%	2.9%	-0.4%
	Urban	2.4%	-1.3%	3.1%	-0.4%	2.4%	-0.6%
	Rural	8.0%	1.5%	5.8%	1.2%	8.0%	2.3%
West North Central (IA,KS,MN,MO, NE,ND,SD)	Total	5.1%	0.3%	3.3%	-0.0%	5.2%	1.0%
	Urban	2.8%	-1.1%	1.5%	-1.2%	2.9%	-0.5%
	Rural	13.0%	5.1%	9.5%	3.7%	13.1%	6.0%
South Atlantic (DE,DC,FL,GA,MD, NC,SC,VA,WV)	Total	-0.6%	-3.9%	-1.4%	-3.5%	-0.6%	-3.3%
	Urban	-2.1%	-5.2%	-2.6%	-4.5%	-2.2%	-4.6%
	Rural	6.3%	1.8%	4.1%	0.9%	6.4%	2.4%
East South Central (AL,KY,MS,TN)	Total	4.4%	0.1%	2.5%	-0.4%	4.5%	0.7%
	Urban	2.6%	-1.6%	0.8%	-2.0%	2.6%	-1.0%
	Rural	10.7%	5.9%	8.2%	4.9%	10.8%	6.6%
West South Central (AS,LA,OK,TX)	Total	-0.4%	-5.4%	-1.9%	-5.3%	-0.5%	-4.8%
	Urban	-1.2%	-5.8%	-2.3%	-5.5%	-1.3%	-5.2%
	Rural	1.2%	-4.4%	-0.9%	-4.9%	1.2%	-3.7%
Mountain (AZ,CO,ID,MT, NV,NM,UT,WY)	Total	2.5%	-2.7%	2.0%	-1.7%	2.4%	-2.0%
	Urban	1.6%	-2.9%	1.5%	-1.8%	1.6%	-2.3%
	Rural	6.5%	-1.6%	4.2%	-1.5%	6.4%	-0.8%
Pacific (AK,CA,HI, OR,WA)	Total	-4.2%	-6.8%	-3.1%	-4.8%	-4.3%	-6.3%
	Urban	-4.3%	-6.9%	-3.2%	-4.8%	-4.4%	-6.3%
	Rural	6.5%	1.0%	4.9%	1.1%	6.5%	1.8%

Source: Congressional Budget Office simulations from PPRC's 1986 BHAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

TABLE 7. PERCENT CHANGE IN BALANCE BILLING AND TOTAL ENROLLEE LIABILITY UNDER REFORM PROPOSALS, BY ENROLLEE GROUP POST-BEHAVIOR EFFECT

	WAYS AND MEANS		ENERGY AND COMMERCE		SENATE FINANCE	
	Balance Billing	Total Liability	Balance Billing	Total Liability	Balance Billing	Total Liability
All Enrollees	-61.0%	-11.9%	-42.4%	-8.3%	-50.8%	-10.0%
Residence						
Very large metro /a/	-60.1%	-14.7%	-45.6%	-10.6%	-50.4%	-12.9%
Large metro /b/	-59.9%	-11.2%	-42.2%	-7.7%	-49.6%	-9.4%
Other metro	-60.7%	-12.0%	-41.3%	-8.4%	-50.4%	-9.9%
Large rural /c/	-62.6%	-11.6%	-42.8%	-8.1%	-52.5%	-9.5%
Other rural	-63.6%	-11.7%	-42.9%	-8.3%	-53.4%	-9.6%
Income as Percent of Poverty Level						
100% - 149%	-61.1%	-10.6%	-41.7%	-7.1%	-50.7%	-8.6%
150% - 199%	-61.1%	-10.6%	-41.7%	-7.1%	-50.6%	-8.7%
200% - 299%	-60.9%	-11.4%	-42.2%	-7.8%	-50.6%	-9.5%
300% or more	-60.3%	-13.4%	-41.6%	-9.5%	-49.9%	-11.3%
Hospitalized						
Yes	-61.0%	-14.8%	-42.2%	-10.7%	-50.8%	-12.6%
No	-61.0%	-8.6%	-42.7%	-5.7%	-50.7%	-7.0%
Age						
Less than 65	-64.8%	-10.6%	-48.8%	-8.1%	-56.3%	-9.3%
65 - 74	-61.1%	-12.8%	-42.5%	-9.1%	-50.9%	-10.8%
75 - 84	-59.7%	-11.5%	-40.4%	-7.8%	-49.1%	-9.5%
85 or more	-61.4%	-9.7%	-42.7%	-6.2%	-51.1%	-7.8%

Source: Congressional Budget Office simulations from PPRC's 1986 BMAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

Note: Poor enrollees and Medicaid beneficiaries are excluded because their copayment and balance-billing costs would be eliminated under the proposals.

a. Population of 5 million or more.
b. Population of 1 to 5 million.
c. Non-metropolitan counties with population of 25,000 or more.

TABLE 8. COST ESTIMATES FOR PHYSICIAN PAYMENT PROVISIONS, FISCAL YEAR 1990
(In millions of dollars)

Provision		WAYS AND MEANS	ENERGY AND COMMERCE	SENATE FINANCE /a/
Reduce Prevailing Charges for Certain Overpriced Procedures	/b/	-200	--	-150
Adjust Prevailing Charges as an MFS Transition Step	/b/	--	0	--
Reduce Prevailing Charge Update for Nonprimary Care (& delay update)	/b/	-460	--	-460
Eliminate Prevailing Charge Update	/b/	--	-670	--
Reduce/Restructure Payments for Radiology Services	/b/	-160	3	-80
Pay Actual Time for Anesthesiology Services		-35	-45	-35
Limit Prevailing Charges to Those of Designated Specialty		-25	--	--
Limit Customary Charges of New Physicians		-25	--	--
Payment for Pathology Services		--	0	--
Clinical Laboratory Fee Schedule		-90	-55	-75
TOTAL COSTS		-995	-767	-800

Source: Congressional Budget Office.

b. Included in simulation results shown on subsequent tables.

a. Senate estimates differ from those prepared for budget reconciliation conference, which include offset for effects of SMI copayment cap. Senate estimates here do not include that offset, to be comparable to estimates provided for House.

TABLE 9. PERCENT CHANGE IN ALLOWED AMOUNTS AND MEDICARE RECEIPTS UNDER FY1990 PROPOSALS, BY SPECIALTY PRE-BEHAVIOR IMPACT

Specialty	WAYS AND MEANS		ENERGY AND COMMERCE		SENATE FINANCE	
	Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts
All Specialties	-5.6%	-4.9%	-4.5%	-3.6%	-4.5%	-4.0%
Medical Specialties	-3.0%	-2.5%	-2.6%	-2.0%	-2.6%	-2.2%
Internal Medicine	-3.2%	-2.7%	-2.6%	-2.1%	-2.8%	-2.4%
Family Practice	-2.3%	-1.9%	-2.1%	-1.6%	-2.0%	-1.7%
Dermatology	-2.1%	-1.7%	-3.3%	-2.7%	-2.0%	-1.7%
Surgical Specialties	-7.1%	-6.1%	-6.2%	-4.7%	-5.9%	-5.2%
Opthalmology	-8.6%	-7.7%	-6.8%	-5.5%	-6.8%	-6.1%
General Surgery	-5.7%	-5.1%	-6.0%	-4.5%	-5.1%	-4.5%
Orthopedic Surgery	-5.5%	-4.6%	-5.5%	-3.9%	-4.7%	-4.0%
Urology	-6.0%	-4.8%	-5.3%	-3.7%	-5.4%	-4.3%
Thoracic Surgery	-10.8%	-9.5%	-8.2%	-6.4%	-9.3%	-8.2%
Otolaryngology	-2.6%	-2.1%	-3.6%	-2.7%	-2.4%	-1.9%
Gynecology	-6.2%	-6.2%	-5.1%	-3.6%	-5.8%	-5.8%
Supporting Specialties	-9.8%	-9.3%	-4.4%	-3.8%	-5.7%	-5.4%
Radiology	-10.8%	-10.4%	-4.5%	-3.8%	-6.1%	-5.9%
Pathology	-2.8%	-2.2%	-4.3%	-3.3%	-2.8%	-2.2%
Other Specialties	-4.5%	-3.9%	-4.1%	-3.4%	-3.9%	-3.5%

Source: Congressional Budget Office simulations from PPRC's 1986 BMAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

Note: See Table 12 for final effects, subsequent to behavioral responses.

TABLE 10. PERCENT CHANGE IN ALLOWED AMOUNTS AND MEDICARE RECEIPTS UNDER FY1990 PROPOSALS, BY GEOGRAPHIC AREA PRE-BEHAVIOR IMPACT

Region		WAYS AND MEANS		ENERGY AND COMMERCE		SENATE FINANCE	
		Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts
Nationwide	Total	-5.6%	-4.9%	-4.5%	-3.6%	-4.5%	-4.0%
	Urban	-5.6%	-4.9%	-4.5%	-3.6%	-4.5%	-4.0%
	Rural	-5.5%	-4.7%	-4.7%	-3.5%	-4.4%	-3.8%
New England (CT,MA,ME, NH,RI,VT)	Total	-4.7%	-4.4%	-4.2%	-3.9%	-3.9%	-3.7%
	Urban	-4.7%	-4.5%	-4.2%	-3.9%	-3.9%	-3.7%
	Rural	-4.2%	-3.7%	-4.5%	-3.8%	-3.9%	-3.4%
Mid-Atlantic (NJ,NY,PA)	Total	-5.7%	-5.2%	-4.3%	-3.7%	-4.7%	-4.3%
	Urban	-5.7%	-5.3%	-4.4%	-3.7%	-4.7%	-4.3%
	Rural	-5.3%	-4.9%	-4.1%	-3.6%	-4.1%	-3.8%
East North Central (OH,IL,IN, MI,WI)	Total	-5.1%	-4.3%	-4.3%	-3.2%	-4.3%	-3.6%
	Urban	-5.1%	-4.3%	-4.2%	-3.2%	-4.3%	-3.7%
	Rural	-5.6%	-4.4%	-4.7%	-3.2%	-4.5%	-3.6%
West North Central (IA,KS,MN,MO, NE,ND,SD)	Total	-4.4%	-3.7%	-4.2%	-3.2%	-3.8%	-3.3%
	Urban	-4.4%	-3.8%	-4.3%	-3.4%	-3.8%	-3.3%
	Rural	-4.2%	-3.4%	-4.1%	-2.7%	-3.8%	-3.0%
South Atlantic (DE,DC,FL,GA,MD, NC,SC,VA,WV)	Total	-6.0%	-5.4%	-4.9%	-3.9%	-4.5%	-4.0%
	Urban	-6.1%	-5.4%	-4.8%	-3.9%	-4.4%	-3.9%
	Rural	-6.0%	-5.4%	-5.0%	-4.0%	-4.6%	-4.1%
East South Central (AL,KY,MS,TN)	Total	-5.1%	-4.4%	-4.5%	-3.6%	-4.0%	-3.4%
	Urban	-5.6%	-4.8%	-4.8%	-3.8%	-4.2%	-3.6%
	Rural	-3.6%	-3.0%	-3.5%	-2.6%	-3.3%	-2.8%
West South Central (AS,LA,OK,TX)	Total	-6.7%	-5.7%	-5.4%	-4.1%	-5.3%	-4.5%
	Urban	-6.5%	-5.6%	-5.4%	-4.0%	-5.2%	-4.4%
	Rural	-7.1%	-6.1%	-5.6%	-4.1%	-5.4%	-4.7%
Mountain (AZ,CO,ID,MT, NV,NM,UT,WY)	Total	-5.3%	-4.5%	-4.2%	-3.1%	-4.7%	-4.0%
	Urban	-5.5%	-4.8%	-4.3%	-3.3%	-4.8%	-4.2%
	Rural	-4.4%	-3.3%	-4.0%	-2.2%	-3.9%	-3.0%
Pacific (AK,CA,HI, OR,WA)	Total	-5.7%	-5.0%	-4.2%	-3.3%	-4.7%	-4.1%
	Urban	-5.7%	-5.0%	-4.2%	-3.3%	-4.7%	-4.1%
	Rural	-3.6%	-2.9%	-3.2%	-2.4%	-3.3%	-2.7%

Source: Congressional Budget Office simulations from PPRC's 1986 BMAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

Note: See Table 13 for final effects, subsequent to behavioral responses.

TABLE 11. PERCENT CHANGE IN BALANCE BILLING AND TOTAL ENROLLEE LIABILITY UNDER FY1990 PROPOSALS, BY ENROLLEE GROUP PRE-BEHAVIOR IMPACT

	WAYS AND MEANS		ENERGY AND COMMERCE		SENATE FINANCE	
	Balance Billing	Total Liability	Balance Billing	Total Liability	Balance Billing	Total Liability
All Enrollees	6.6%	-2.1%	12.2%	-0.4%	5.4%	-1.7%
Residence						
Very large metro /a/	6.3%	-2.9%	11.5%	-0.9%	5.3%	-2.4%
Large metro /b/	6.3%	-2.4%	11.3%	-0.8%	5.1%	-2.0%
Other metro	6.9%	-1.9%	12.6%	-0.1%	5.5%	-1.5%
Large rural /c/	6.7%	-1.9%	12.7%	-0.1%	5.4%	-1.5%
Other rural	7.0%	-1.5%	13.5%	0.3%	5.9%	-1.1%
Income as Percent of Poverty Level						
100% - 149%	6.3%	-2.0%	12.5%	-0.3%	5.0%	-1.6%
150% - 199%	6.4%	-2.1%	12.7%	-0.3%	5.0%	-1.7%
200% - 299%	6.8%	-2.1%	12.1%	-0.4%	5.6%	-1.6%
300% or more	7.0%	-2.2%	12.5%	-0.3%	5.7%	-1.7%
Hospitalized						
Yes	6.4%	-2.6%	12.6%	-0.4%	5.4%	-2.1%
No	7.0%	-1.6%	11.5%	-0.4%	5.4%	-1.2%
Age						
Less than 65	4.9%	-2.2%	9.7%	-1.0%	4.2%	-1.8%
65 - 74	6.6%	-2.0%	12.3%	-0.2%	5.3%	-1.6%
75 - 84	7.2%	-2.2%	12.8%	-0.4%	5.8%	-1.8%
85 or more	6.7%	-2.0%	11.6%	-0.5%	5.7%	-1.6%

Source: Congressional Budget Office simulations from PPRC's 1986 BMAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

Note: See Table 14 for final effects, subsequent to behavioral responses. Poor enrollees and Medicaid beneficiaries are excluded because their copayment and balance-billing costs would be eliminated under the proposals.

a. Population of 5 million or more.
b. Population of 1 to 5 million.
c. Non-metropolitan counties with population of 25,000 or more.

TABLE 12. PERCENT CHANGE IN ALLOWED AMOUNTS AND MEDICARE RECEIPTS UNDER FY1990 PROPOSALS, BY SPECIALTY
POST-BEHAVIOR EFFECT

Specialty	WAYS AND MEANS		ENERGY AND COMMERCE		SENATE FINANCE	
	Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts
All Specialties	-2.8%	-2.2%	-2.5%	-1.6%	-2.3%	-1.8%
Medical Specialties	-1.6%	-1.1%	-1.4%	-0.9%	-1.4%	-1.0%
Internal Medicine	-1.7%	-1.2%	-1.4%	-0.9%	-1.5%	-1.1%
Family Practice	-1.3%	-0.9%	-1.2%	-0.7%	-1.1%	-0.7%
Dermatology	-1.1%	-0.8%	-1.7%	-1.2%	-1.1%	-0.7%
Surgical Specialties	-3.6%	-2.7%	-3.5%	-2.1%	-3.0%	-2.3%
Opthalmology	-4.4%	-3.4%	-3.7%	-2.5%	-3.4%	-2.7%
General Surgery	-2.9%	-2.3%	-3.4%	-2.0%	-2.6%	-2.0%
Orthopedic Surgery	-2.9%	-2.0%	-3.3%	-1.7%	-2.5%	-1.8%
Urology	-3.4%	-2.1%	-3.2%	-1.7%	-3.0%	-1.9%
Thoracic Surgery	-5.5%	-4.2%	-4.6%	-2.9%	-4.7%	-3.6%
Otolaryngology	-1.4%	-0.9%	-2.1%	-1.2%	-1.3%	-0.9%
Gynecology	-2.8%	-2.8%	-3.1%	-1.6%	-2.5%	-2.6%
Supporting Specialties	-4.6%	-4.2%	-2.3%	-1.6%	-2.7%	-2.4%
Radiology	-5.0%	-4.6%	-2.3%	-1.7%	-2.9%	-2.6%
Pathology	-1.6%	-1.0%	-2.4%	-1.5%	-1.5%	-1.0%
Other Specialties	-2.3%	-1.8%	-2.2%	-1.5%	-2.0%	-1.5%

Source: Congressional Budget Office simulations from PPRC's 1986 BMAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

TABLE 13. PERCENT CHANGE IN ALLOWED AMOUNTS AND MEDICARE RECEIPTS UNDER FY1990 PROPOSALS, BY GEOGRAPHIC AREA
POST-BEHAVIOR EFFECT

Region		WAYS AND MEANS		ENERGY AND COMMERCE		SENATE FINANCE	
		Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts	Allowed Amounts	Medicare Receipts
Nationwide	Total	-2.8%	-2.2%	-2.5%	-1.6%	-2.3%	-1.8%
	Urban	-2.8%	-2.2%	-2.4%	-1.6%	-2.3%	-1.8%
	Rural	-2.9%	-2.1%	-2.7%	-1.5%	-2.3%	-1.7%
New England (CT,MA,ME, NH,RI,VT)	Total	-2.2%	-2.0%	-2.1%	-1.7%	-1.8%	-1.7%
	Urban	-2.2%	-2.0%	-2.0%	-1.7%	-1.8%	-1.7%
	Rural	-2.2%	-1.6%	-2.4%	-1.7%	-1.9%	-1.5%
Mid-Atlantic (NJ,NY,PA)	Total	-2.8%	-2.3%	-2.3%	-1.6%	-2.3%	-1.9%
	Urban	-2.8%	-2.3%	-2.3%	-1.6%	-2.3%	-1.9%
	Rural	-2.6%	-2.2%	-2.1%	-1.6%	-2.0%	-1.7%
East North Central (OH,IL,IN, MI,WI)	Total	-2.7%	-1.9%	-2.5%	-1.4%	-2.3%	-1.6%
	Urban	-2.7%	-1.9%	-2.4%	-1.4%	-2.3%	-1.6%
	Rural	-3.1%	-2.0%	-2.9%	-1.4%	-2.5%	-1.6%
West North Central (IA,KS,MN,MO, NE,ND,SD)	Total	-2.3%	-1.7%	-2.4%	-1.4%	-2.0%	-1.5%
	Urban	-2.2%	-1.7%	-2.4%	-1.5%	-2.0%	-1.5%
	Rural	-2.3%	-1.5%	-2.6%	-1.2%	-2.1%	-1.4%
South Atlantic (DE,DC,FL,GA,MD, NC,SC,VA,WV)	Total	-3.1%	-2.4%	-2.7%	-1.7%	-2.3%	-1.8%
	Urban	-3.1%	-2.4%	-2.7%	-1.7%	-2.3%	-1.7%
	Rural	-3.0%	-2.4%	-2.7%	-1.8%	-2.3%	-1.8%
East South Central (AL,KY,MS,TN)	Total	-2.6%	-2.0%	-2.5%	-1.6%	-2.1%	-1.5%
	Urban	-2.8%	-2.2%	-2.7%	-1.7%	-2.1%	-1.6%
	Rural	-1.9%	-1.3%	-2.0%	-1.2%	-1.8%	-1.2%
West South Central (AS,LA,OK,TX)	Total	-3.5%	-2.5%	-3.1%	-1.8%	-2.7%	-2.0%
	Urban	-3.4%	-2.5%	-3.1%	-1.8%	-2.7%	-2.0%
	Rural	-3.6%	-2.7%	-3.3%	-1.8%	-2.8%	-2.1%
Mountain (AZ,CO,ID,MT, NV,NM,UT,WY)	Total	-2.8%	-2.0%	-2.5%	-1.4%	-2.4%	-1.8%
	Urban	-2.8%	-2.1%	-2.4%	-1.4%	-2.5%	-1.9%
	Rural	-2.5%	-1.5%	-2.7%	-1.0%	-2.3%	-1.3%
Pacific (AK,CA,HI, OR,WA)	Total	-2.9%	-2.2%	-2.3%	-1.5%	-2.4%	-1.8%
	Urban	-2.9%	-2.2%	-2.3%	-1.5%	-2.4%	-1.8%
	Rural	-1.9%	-1.3%	-1.8%	-1.1%	-1.8%	-1.2%

Source: Congressional Budget Office simulations from PPRC's 1986 BMAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

TABLE 14. PERCENT CHANGE IN BALANCE BILLING AND TOTAL ENROLLEE LIABILITY UNDER FY1990 PROPOSALS, BY ENROLLEE GROUP
POST-BEHAVIOR EFFECT

	WAYS AND MEANS		ENERGY AND COMMERCE		SENATE FINANCE	
	Balance Billing	Total Liability	Balance Billing	Total Liability	Balance Billing	Total Liability
All Enrollees	8.9%	0.0%	13.9%	1.2%	7.3%	0.0%
Residence						
Very large metro /a/	8.9%	-0.4%	13.4%	0.8%	7.5%	-0.3%
Large metro /b/	8.6%	-0.2%	13.0%	0.8%	7.0%	-0.2%
Other metro	9.1%	0.2%	14.2%	1.4%	7.4%	0.2%
Large rural /c/	8.9%	0.1%	14.3%	1.4%	7.2%	0.1%
Other rural	9.0%	0.3%	15.0%	1.7%	7.5%	0.3%
Income as Percent of Poverty Level						
100% - 149%	8.5%	0.0%	14.1%	1.2%	6.8%	0.0%
150% - 199%	8.6%	0.0%	14.4%	1.2%	6.8%	0.0%
200% - 299%	9.1%	0.0%	13.7%	1.1%	7.4%	0.1%
300% or more	9.4%	0.0%	14.2%	1.3%	7.7%	0.0%
Hospitalized						
Yes	8.8%	-0.1%	14.3%	1.4%	7.4%	-0.1%
No	9.1%	0.1%	13.1%	0.9%	7.1%	0.2%
Age						
Less than 65	7.0%	-0.3%	11.3%	0.5%	5.9%	-0.2%
65 - 74	8.8%	0.1%	14.0%	1.3%	7.2%	0.0%
75 - 84	9.5%	-0.1%	14.5%	1.2%	7.7%	0.0%
85 or more	8.9%	0.0%	13.3%	1.1%	7.5%	0.1%

Source: Congressional Budget Office simulations from PPRC's 1986 BMAD beneficiary file, aged by CBO to 1990. All physicians' claims except for anesthesiology services and all claims by limited license practitioners were retained, but all claims by suppliers were eliminated.

Note: Poor enrollees and Medicaid beneficiaries are excluded because their copayment and balance-billing costs would be eliminated under the proposals.

a. Population of 5 million or more.
b. Population of 1 to 5 million.
c. Non-metropolitan counties with population of 25,000 or more.