100th Congress
2d Session

COMMITTEE PRINT

S. PRT.
100-134

MEDICARE PHYSICIAN REIMBURSEMENT: ISSUES AND OPTIONS

AN INFORMATION PAPER

PREPARED BY THE STAFF OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

SEPTEMBER 1988

Serial No. 100-L

This document has been printed for information purposes. It does not offer findings or recommendations by this committee

U.S. GOVERNMENT PRINTING OFFICE

89-274

WASHINGTON : 1988

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

89-274 - 88 - 1

SENATE SPECIAL COMMITTEE ON AGING

JOHN MELCHER, Montana, *Chairman*

JOHN GLENN, Ohio
LAWTON CHILES, Florida
DAVID PRYOR, Arkansas
BILL BRADLEY, New Jersey
QUENTIN N. BURDICK, North Dakota
J. BENNETT JOHNSTON, Louisiana
JOHN B. BREAUX, Louisiana
RICHARD SHELBY, Alabama
HARRY REID, Nevada

JOHN HEINZ, Pennsylvania
WILLIAM S. COHEN, Maine
LARRY PRESSLER, South Dakota
CHARLES E. GRASSLEY, Iowa
PETE WILSON, California
PETE V. DOMENICI, New Mexico
JOHN H. CHAFEE, Rhode Island
DAVE DURENBERGER, Minnesota
ALAN K. SIMPSON, Wyoming

MAX I. RICHTMAN, *Staff Director*
G. LAWRENCE ATKINS, *Minority Staff Director*
CHRISTINE DRAYTON, *Chief Clerk*

PREFACE

The Special Committee on Aging has long been concerned with the adequacy and financial health of the Medicare program. Although Congress has historically focused most of its attention on cost containment within the Medicare Hospital Insurance trust fund, also known as Part A, congressional efforts have increasingly turned to needed reforms under the physician reimbursement system under the Supplemental Medical Insurance (SMI), or Part B.

This information paper was prepared as a follow-up to a 1987 Committee hearing on the effects of rising Part B expenditures on beneficiaries' out-of-pocket costs. It provides an overview of the organization and design of the current physician reimbursement system under the Medicare SMI program, as well as a discussion of the various physician payment reform options currently under consideration. Its purpose is to provide an historical perspective for discussion of reform that takes into account beneficiary and provider interests while controlling escalating costs.

In our endeavor to acknowledge the many points of view on this issue, the Committee requested comments from various organizations representing the elderly as well as numerous physician groups. We are pleased that so many were able to respond to our request.

This information print was prepared by Holly Bode, professional staff member on the Aging Committee. The Committee and the author are indebted to many people for their assistance in preparing this paper, and we particularly wish to thank Gloria Ruby and others at the Office of Technology Assessment.

JOHN MELCHER,
Chairman.
JOHN HEINZ,
Ranking Minority Member.

EXECUTIVE SUMMARY

The Medicare Supplemental Medical Insurance (SMI) program, or Part B, covers physicians' services, outpatient hospital services, physical therapy, diagnostic and X-ray services, durable medical equipment and certain other services. SMI is a voluntary, non-means-tested program, and anyone eligible for Part A (Hospital Insurance) and anyone over 65 can obtain Part B coverage by paying a monthly premium ($24.80 in 1988). Total Medicare outlays in fiscal year 1987 were $83 billion; of this amount, $31 billion were under Part B.

The SMI program is financed by a combination of beneficiary premiums, general revenues and SMI trust fund interest. Medicare beneficiaries' growing out-of-pocket liability has become an issue of concern—Part B enrollees' out-of-pocket expenses have increased 194 percent since 1975. Similarly, Medicare expenditures on physician services under Part B have increased dramatically. In the years between 1983 and 1986, physician expenditures under Medicare increased at an annual rate of 9.1 percent, compared to 7.2 percent for all physicians.

To put this issue in perspective, Americans spend more per capita on health care than any industrialized nation, and at an ever-increasing rate. In 1968, national health expenditures were only 6.3 percent of the Gross National Product (GNP), compared to 10.6 percent in 1985 and 11.2 percent in 1987. Medicare represented 17 percent of total national health expenditures in 1985—about 1.81 percent of GNP.

The present fee-for-service physician reimbursement system is based on customary, prevailing, and reasonable (CPR) charges. Physicians have the option to accept "assignment" of the claim, in which he/she agrees to accept Medicare's approved charge as payment in full. Physicians may accept assignment on a bill-by-bill basis, patient-by-patient, etc., unless he/she is a "participating physician." Participating physicians agree to accept assignment on all services provided to all Medicare patients for a specified period of time.

There are a number of problems with the fee-for-service reimbursement system. Among these are the inherently inflationary tendencies of the CPR system, and its lack of incentives to provide cost-effective care. Other problems such as wide geographic variation in reimbursement rates, its emphasis on procedural services, and the disparities among reimbursement rates for various specialties have also been cited.

Recent legislation, beginning with the Deficit Reduction Act of 1984 (DEFRA) has made numerous modifications in the physician payment provisions of Medicare. These changes include the fee freeze under DEFRA, "inherent reasonableness" under COBRA and OBRA, and "reasonable charge" reductions under OBRA 1987.

None of these changes, however, is considered to be long-term solutions to controlling expenditures under Part B. The more fundamental physician payment reform options, as detailed by the Office of Technology Assessment, the Physician Payment Review Commission, and others include modifying the current system, the development of a fee schedule, "bundling" of services, and capitation.

In conclusion, congressional leaders examining changes to the present reimbursement system will face intense pressure to recognize the interests of beneficiaries (in terms of limiting out-of-pocket liability and ensuring access to quality care), the desire of physicians to protect their incomes as well as maintain a degree of autonomy in terms of their practice, and the importance of controlling costs in the face of an overwhelming Federal deficit.

CONTENTS

	Page
PREFACE	III
EXECUTIVE SUMMARY	V
INTRODUCTION	1
I. THE MEDICARE SUPPLEMENTAL MEDICAL INSURANCE PROGRAM	1
II. BENEFICIARY COST-SHARING AND THE MEDICARE PROGRAM	3
III. GROWTH IN PHYSICIAN EXPENDITURES	6
IV. HEALTH EXPENDITURES IN THE UNITED STATES	8
V. PHYSICIAN SERVICES AND THE SMI PROGRAM	13
A. Medicare Physician Reimbursement	15
B. Definition of Assignment	15
C. The Participating Physician Program	17
D. Physician Income	19
VI. PROBLEMS WITH THE CURRENT PHYSICIAN REIMBURSEMENT SYSTEM	20
A. Geographic Variation in Reimbursement	22
B. Nonprocedural and Procedural Fee Differentials	23
C. Inherent Reasonableness	23
D. Specialty Variations	24
VII. RECENT LEGISLATION	25
A. DEFRA	26
B. COBRA	26
C. OBRA 1986	27
D. OBRA 1987	27
VIII. PHYSICIAN PAYMENT REFORM OPTIONS	29
A. Fee Schedules	30
B. Physician DRG's	32
C. Capitation	33
D. Modifying the Current System	34
IX. CONCLUSION	34
BIBLIOGRAPHY	35
APPENDIX 1.—COMMENTS ON PHYSICIAN PAYMENT REFORM BY AGING ADVOCACY ORGANIZATIONS AND PHYSICIANS' ORGANIZATIONS	37
Item 1. Sample letter of Invitation to Submit Comments	37
Item 2. Comments by the American Association of Retired Persons	38
Item 3. Comments by the Gray Panthers	44
Item 4. Comments by the National Committee to Preserve Social Security and Medicare	47
Item 5. Comments by the American Academy of Family Physicians	50
Item 6. Comments by the American Academy of Ophthalmology	68
Item 7. Comments by the American Academy of Otolaryngology—Head and Neck Surgery	72
Item 8. Comments by the American College of Cardiology	74
Item 9. Comments by the American College of Surgeons	75
Item 10. Comments by the American Medical Association	77
Item 11. Comments by the American Osteopathic Association	86
Item 12. Comments by the American Psychiatric Association	88
Item 13. Comments by the American Society of Internal Medicine	91
Item 14. Comments by the American Urological Association	100

INTRODUCTION

The following report presents an overview of the Medicare Supplemental Medical Insurance (SMI) program, also known as Part B. The SMI program, which covers primarily physicians' services and hospital outpatient services, has received a great deal of attention lately as a result of ever-increasing expenditures on physicians' services. The 1988 monthly Part B premium increased an unprecedented 38.5 percent from 1987, giving Congress and other policymakers an incentive to begin serious consideration of various reforms to the present reimbursement system.

This has lead many to believe that fundamental changes to the system are likely to occur within the next few years. Although there is no consensus on the "ideal" physician reimbursement system, physicians, beneficiaries, advocacy groups for the aged, health insurance companies, Congress, and the Reagan administration agree that some type of reform is necessary—and imminent.

This report was written to provide a compendium of the information currently available on the SMI program, and to establish a framework for the discussion of possible alterations to the present system. The views of the aforementioned groups have been taken into account in writing this report in an attempt to present a balanced account.

I. The Medicare Supplemental Medical Insurance Program

The Medicare Supplemental Medical Insurance program, or Part B, covers physicians' services, outpatient hospital services, physical therapy, diagnostic and X-ray services, durable medical equipment and certain other services. SMI is a voluntary, non-means-tested program, and anyone eligible for Part A (Hospital Insurance) and anyone over 65 can obtain Part B coverage by paying a monthly premium ($24.80 in 1988). The Medicare Program is administered by the Health Care Financing Administration (HCFA) at the Department of Health and Human Services (DHHS).

In 1987, about 29 million elderly and 3 million disabled persons were entitled to Part A benefits. Nearly all of the aged and about 92 percent of the disabled who were entitled to Part A opted for Part B coverage. Between 1981 and 1985, growth in the Medicare enrollment rate for the aged averaged just over 2 percent annually. This rate is expected to decline slightly and then accelerate around 2010 as the baby-boom generation begins to reach age 65.

Federal Outlays

Total Medicare outlays in fiscal year 1987 were $83 billion; of this amount, $51.7 billion were Part A outlays and $31 billion were Part B. Reimbursement for physicians' services under Part B in fiscal year 1987 was $21.9 billion, which represented nearly 75 per-

cent of Part B outlays and 25 percent of total Medicare expenditures. The administration estimates that payments for physicians' services will total $24.7 billion in fiscal year 1988, which will be 28 percent of total estimated Medicare outlays.

Financing and Beneficiary Cost-Sharing

The SMI program is financed by a combination of beneficiary premiums, deductibles, and copayments, general revenues and SMI trust fund interest. Beneficiaries must pay a monthly premium of $24.80 in 1988, or $297.60 per year, up from $36 per year in 1966. Before SMI benefits begin, beneficiaries must meet an annual deductible of $75 paid against charges allowed by Medicare. After the deductible is met, the beneficiary is liable for 20 percent of Medicare allowable charges for covered physician services.

The Medicare Catastrophic Coverage Act of 1988

The Medicare Catastrophic Coverage Act of 1988, which was signed by the President into Public Law 100-360 on July 1, 1988, represents the largest expansion of the Medicare Program in its history. The benefits provided under this legislation include 365 days of inpatient hospital coverage with a one-time deductible, an expansion of the skilled nursing and home health care benefits, and a new outpatient drug benefit.

While physicians' services were not expanded under this law, there are provisions which will work to protect beneficiaries from incurring catastrophic physicians' bills. Beginning in 1990, once a beneficiary incurs *out-of-pocket* Part B covered expenditures (i.e., the $75 deductible and the 20 percent copayment) which exceed the Part B catastrophic limit ($1,370 in 1990), Medicare will be required to pay 100 percent of reasonable charges for any additional Part B covered services. In other words, after a beneficiary exceeds Medicare Part B allowed charges in excess of $6,550, he/she will be eligible for the catastrophic coverage.

The new Medicare coverage will begin regardless of whether the beneficiary meets the Part B catastrophic limit through payments from a private medigap insurance policy or directly out of the beneficiary's pocket. It is important to note, however, that charges in excess of the Medicare approved or allowed amount, of so-called "balance-billing", do not count toward the catastrophic limit.

The new Medicare benefits will be financed by a combination of an additional flat premium, which all Part B enrollees will pay, and by an income based supplemental premium, which beneficiaries with over $150 in tax liability will pay. The monthly Part B premium will increase by an additional $4 per month in 1989, rising each year up to an estimated $10.20 per month in 1993. In addition, all Medicare beneficiaries (even the small population of beneficiaries who have not opted for Part B coverage) who pay over $150 in taxes will pay an extra premium based on their taxable income. Beginning in taxable year 1989, an additional yearly premium of $22.50 will be levied for each $150 in tax liability, up to a maximum of $800. The minimum supplemental premium will increase each year up to $42 in 1993.

In subsequent years, the catastrophic health care premium rates will be adjusted to cover annual increases in program costs and

any unanticipated shortfalls. This indexing mechanism is designed to assure that beneficiary payments will continue to cover the costs of the new and expanded benefits.

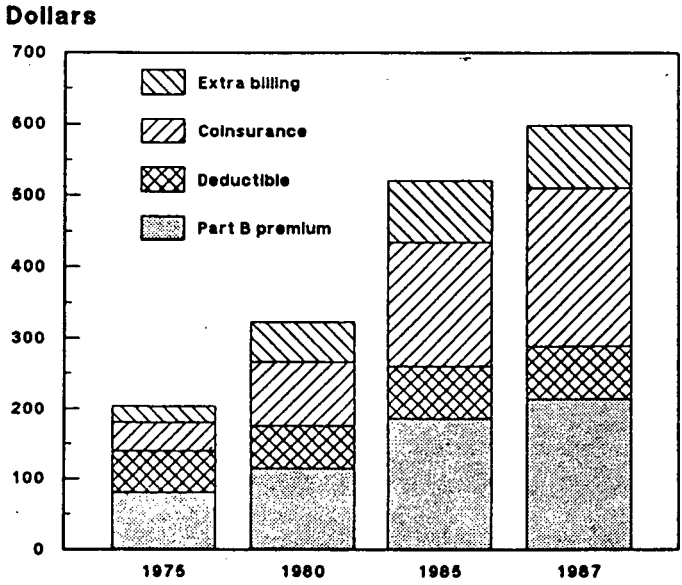
Until 1972, premiums for SMI were to cover half of program costs and general revenues the rest. As outlays increased during the early years of the program, Congress limited increases in beneficiary premiums to the percentage of the cost-of-living increase in Social Security cash benefits. This changed in 1984, and for the 5-year period beginning January 1, 1984, enrollee premiums must equal 25 percent of the average monthly benefit per aged enrollee. This was extended until the end of calendar year 1989 by the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-202). Because contributions from general revenues must make up the difference between premium income and program costs, the solvency of the SMI trust fund is not directly endangered by rising outlays. Instead, the burden falls on general revenues.

The Part B program is financed on an accrual basis with a contingency margin. In other words, it is a "pay as you go" program, and is financed through premiums paid by current beneficiaries. This is in contrast to Part A (or Hospital Insurance) of the Medicare Program, which is financed by the working population through a payroll tax. The Part B trust fund balance should always be somewhat greater than the claims that have been incurred by enrollees but not yet paid by the program. The extra funds are called a "contingency reserve"; the amount varies, but is generally equal approximately 1 to 2 months of funding to cover any error in forecasted expenditures. It is up to HCFA actuaries to determine how much of a contingency reserve is desirable; it is not determined by any regulations or statutes.

II. Beneficiary Cost-Sharing and the Medicare Program

Aged SMI beneficiaries' average liability for out-of-pocket payments has increased by 194 percent from 1975 to 1987—from $204 per enrollee to $600 per enrollee. Coinsurance and extra billing have been the fastest growing components (Figure 1).

FIGURE 1
AVERAGE ESTIMATED OUT-OF-POCKET COSTS PER AGED ENROLLEE FOR COVERED PART B SERVICES SELECTED YEARS: 1975-1987



SOURCE: HEALTH CARE FINANCING ADMINISTRATION
OFFICE OF THE ACTUARY, DIVISION OF COST ESTIMATES

The Medicare Part A deductible has increased by nearly 165 percent since 1981, from $204 to $540 in 1988; this increase is more than five times the general inflation rate during this period. The Part B monthly premium has grown at about the same rate. It was $9.60 in 1980, compared to $24.80 in 1988, an increase of nearly 160 percent.

Among the factors affecting increased out-of-pocket expenditures under the Medicare Program is the Prospective Payment System (PPS) for hospital care under Part A. According to the Prospective Payment Commission's (ProPAC) April 1987 report to the Secretary of DHHS, "cost-sharing borne by Medicare beneficiaries has inadvertently increased as a result of PPS." [1] ProPAC contends that the cost savings realized from PPS have been shared with hospitals and the Medicare Program, but not with beneficiaries. For example, the inpatient hospital deductible is calculated to reflect average length of stay. Until 1986, the formula was based on the longer average length of stay that occurred before PPS was implemented in 1983. Although a provision in the Omnibus Budget Reconciliation Act of 1986 recalibrates future increases in the deductible to reflect the shorter length of stay resulting from incentives in PPS, beneficiaries are still paying a higher proportion of costs per case than before PPS. In 1983, beneficiary copayments and deductibles for inpatient hospital care accounted for about 8 percent of payments to hospitals; in 1987, that figure was about 9.2 percent.[2]

ProPAC reports that PPS incentives to shift services from the inpatient setting to ambulatory settings and to discharge patients after shorter hospital stays may also affect beneficiary out-of-pocket spending.[3] Medicare coverage varies by place and by type of treatment, so coinsurance liability can change depending on where the service is provided. For example, if a surgery is performed in an outpatient setting as opposed to an inpatient hospital setting, beneficiary cost-sharing liability would usually be less. However, if a beneficiary is treated as an inpatient but is then discharged earlier for additional treatment on an outpatient basis, the beneficiary must then pay for the coinsurance of the outpatient facility (under Part B) as well as the inpatient hospital deductible (under Part A). Further, there may be some services that would be covered in an inpatient setting but not in an outpatient one.

A beneficiary who has surgery in an outpatient hospital department is responsible for 20 percent of the facility's charges. Charges for the surgery would have to be at least $2,700 for a beneficiary to incur more than $540 (the inpatient hospital deductible) in coinsurance. In fiscal year 1987, the national average facility charge for cataract surgery in a hospital outpatient department is $1,575; beneficiary liability for those charges would be $315. However, if outpatient coinsurance must be paid in addition to the inpatient deductible, which would occur if a beneficiary is released earlier from

---

[1] Prospective Payment Assessment Commission, *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services; April 1, 1987,* (Washington, D.C.: Prospective Payment Assessment Commission, 1987), p. 48.

[2] Prospective Payment Assessment Commission, April 1987, p. 48.

[3] Prospective Payment Assessment Commission, *Medicare Prospective Payment and the American Health Care System. Report to Congress* (Washington, D.C.; Prospective Payment Assessment Commission, 1987), p. 73.

the hospital to receive additional treatment in an outpatient setting, his financial liability increases. ProPAC is currently working with the Congressional Budget Office (CBO) to develop a data base for studying beneficiary cost-sharing changes and increased liability because of site-of-care substitution.

Most older Americans have some type of supplemental, "medigap" insurance coverage that helps defray some of their out-of-pocket costs for health care services provided under the Medicare Program. According to CBO, approximately 18 million—or 72 percent—of the noninstitutionalized elderly had some form of private supplemental insurance in 1984. Recent analysis of the determinants of medigap coverage by HCFA found that certain demographic characteristics had a significant impact on whether or not a Medicare beneficiary had private supplemental coverage.[4] The individuals least likely to have the coverage are older, unmarried, poorer, less educated, and of races other than white. In other words, those most in need of financial protection are least likely to have it. As these persons are presumably severely affected by large out-of-pocket health care costs, they bear a disproportionate share of the risks of catastrophic illness.

III. Growth in Physician Expenditures

Spending for all physician services has increased dramatically since 1965—from $8.5 billion to $82.8 billion in 1985. In 1986, expenditures for physician services in the United States grew to $92 billion, which is an increase of 11.1 percent from 1985.[5] This represents 2.2 percent of the GNP, and almost three-fourths of the amount of expenditures for community hospital inpatient services ($125.7 billion). HCFA actuaries project that expenditures for physician services will rise to $133 billion in 1990 and to $320 billion in 2000.

Both hospital admissions and inpatient days were lower in 1986 than in 1985, which suggests fewer physician contacts in an inpatient setting. However, data on employment and hours implies strong growth in physician activity in 1986. Total employment in offices of physicians and surgeons increased 6.6 percent, and hours worked by nonsupervisory employees increased 7.3 percent; both of these figures are the highest in decades. Nonsupervisory payroll was up 11.8 percent from 1985, which also suggests considerable strength in office business.[6] HCFA estimates that "reasonable charge reductions" under Medicare Part B (i.e., the difference between what the physician actually bills and what the Medicare Program recognizes as allowed charges) will be shown to have increased about $200 million from 1985 to 1986, which could result in

---

[4] Steven A. Garfinkel, Arthur J. Bonito, and Kenneth R. McLeroy, "Socioeconomic Factors and Medicare Supplemental Health Insurance," *Health Care Financing Review,* Fall, 1987, vol. 9, No. 1, p. 22.

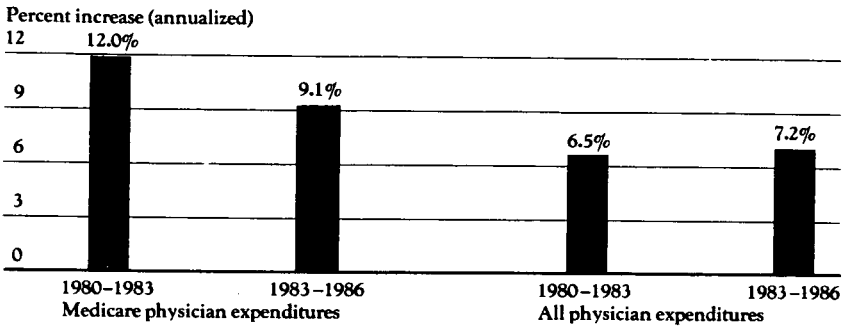
[5] Health Care Financing Administration, Office of the Actuary, Division of Cost Estimates, "National Health Expenditures, 1986–2000" *Health Care Financing Review,* Summer, 1987, Vol. 8, No. 4, p. 11.

[6] Bureau of Labor Statistics, data from the establishment survey, *Employment and Earnings* (Washington: U.S. Government Printing Office), various issues in 1986 and 1987. As cited in "National Health Expenditures, 1986–2000."

an increase in beneficiary liability depending on the number of assigned and nonassigned claims.

During the period from 1980 to 1983, Medicare physician expenditures increased (adjusted for inflation) at an average annual rate of 12 percent, compared to 6.5 percent for all physician expenditures. From 1983 to 1986, expenditures increased at a rate of 9.1 percent and 7.2 percent, respectively (figure 2).[7] During 1986, expenditures for physician services in the Medicare Program increased at the same rate (11.1 percent) as overall physician expenditures, 10 times faster than the overall inflation rate.

FIGURE 2
RATES OF INCREASE IN MEDICARE PHYSICIAN EXPENDITURES AND ALL PHYSICIAN EXPENDITURES 1980-1983 AND 1983-1986 (ADJUSTED FOR INFLATION)



SOURCE: Gerard F. Anderson and Jane E. Erickson, "National Medical Care Spending," Health Affairs, 6, no. 3.

The different rates of increase in expenditures suggest that Medicare beneficiaries receive a higher volume of physicians' services than the rest of the population. Whether this is a result of Medicare beneficiaries needing more services because of poorer health or incentives within the current reimbursement system to increase the volume of services per beneficiary is a matter of great debate.

In January 1988, the Medicare Part B monthly premium was increased from $17.90 to $24.80. According to HCFA, this unprece-

[7] Gerard F. Anderson and Jane E. Erickson, "National Medical Care Spending," *Health Affairs*, Vol. 6, No. 3, Fall, 1987, p. 101.

dented $6.90 increase (38.5 percent) was the result of several factors. Sixty percent of the total premium increase ($4.05 of the $6.90) was due to growth in physician expenditures. Further, HCFA's projections for 1987 were inaccurate, and incurred expenditures for 1987 were 12.1 percent higher than projected. This accounts for $2.40 of the increase. Of this amount, growth in reimbursement to physicians accounts for more than 90 percent of the increase. HCFA's actuarial estimates also show Part B expenditures increasing 13.9 percent in 1988. This growth accounts for $3 of the $6.90 premium increase; 63 percent of this increase is the result of projected increases in physician expenditures.

Additionally, the computation of the monthly Part B premium has taken into account a surplus in the trust fund for the past few years. As a result, the monthly premium has been artificially low because it was adjusted downward to reflect the surplus. For example, the 1987 premium would have been $19.30 rather than $17.90 if projected expenditures had not been partially funded by drawing down the contingency reserve. For calendar year 1988, however, the surplus no longer exists, and $1.43 of the $6.90 increase reflects that. The remaining 7 cents is targeted toward rebuilding the depleted contingency reserve fund.

IV. Health Expenditures in the United States

To put the discussion of growing Part B outlays on physician services in its proper perspective, it is important to consider overall health expenditures in the United States. In 1986, Americans spent $458 billion on health care, or 10.9 percent of the Gross National Product (GNP), compared to 10.6 percent of GNP in 1985 and 9.1 percent in 1980. Health care expenditures increased 8.4 percent from 1985 to 1986, which was slightly lower than the rate of increase in most recent years. However, after adjusting this amount for overall inflation and population growth, expenditures increased 6.3 percent during 1986, a rate much faster than in the years between 1980 and 1985. This represents real growth in health spending, which translates into an increase in service intensity. Service intensity is the area of greatest concern as it means that more technology, personnel, and services are being used per capita.[8]

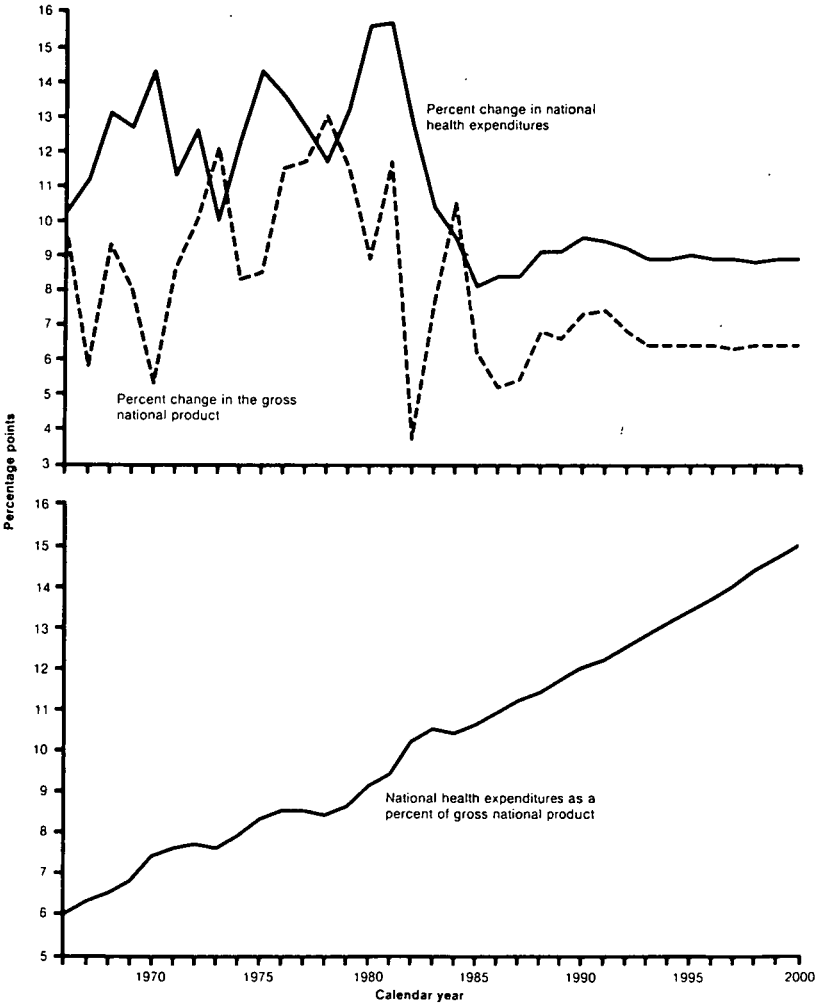
Americans already spend more for health care than almost any other developed nation. Data collected by HCFA on 12 nations, including Great Britain, France, Sweden, and Canada, show that the United States pays the largest percentage of its gross domestic product (a measure similar to GNP) for health care; compared to our 10.9 percent, Great Britain pays 6 percent and Norway pays 6.9 percent.

National health expenditures have increased over the past 50 years in aggregate terms, on a per capita basis, and as a percent of the GNP. During the 1970's, national health expenditures grew at an average annual rate of 12.6 percent; in 1980 and 1981, expenditures grew by over 15 percent each year. Since 1981, however, the rate of growth in health care expenditures has decreased. Growth rates in 1985 (8.1 percent), 1986 and 1987 (8.4 percent each year),

[8] Anderson and Erickson, p. 98.

are the lowest in over two decades (figure 3). This slower growth, which is expected to continue until 2000, can be attributed to several factors, including a low rate of inflation in the general economy, increased pressure to contain health care costs in both the private and public sectors, and changing demands for health care services, such as a decline in the demand for inpatient hospital services.

FIGURE 3
PERCENT CHANGE IN NATIONAL HEALTH EXPENDITURES & GNP NATIONAL HEALTH EXPENDITURES AS A PERCENT OF GNP: CALENDAR YEARS 1966-1986 AND PROJECTIONS 1987-2000



SOURCE: Health Care Financing Administration, Office of the Actuary. Data from the Division of National Cost Estimates

With an upturn in growth of national health expenditures last year, and a downturn in growth of the gross national product (GNP), health spending rose to 10.9 percent of the GNP in 1986. Barring unforeseen events and assuming that current laws and regulations continue into the future, health expenditures will continue to grow more rapidly than will the rest of the economy through the end of the century, by which time health spending will account for 15 percent of the GNP.

In 1986, per capita spending for health care in the United States was $1,837, compared to $1,710 in 1985 and $205 in 1965.[9] HCFA estimates that this figure will increase to $5,551 by 2000. Growth in this area over the years has generally exceeded growth in the general economy. The same is true relative to price inflation—although the Consumer Price Index (CPI) rose only 1.9 percent in 1986, the medical care CPI rose 7.5 percent. While HCFA suggests that medical care inflation can be compared more realistically to inflation in the service sector, where prices rose 5 percent in 1986, it is nonetheless a significant increase.

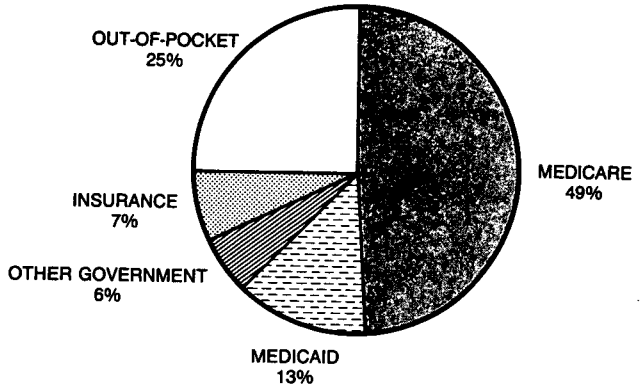
In the years 1980–86, spending on the individual components of the health care market increased at widely varying rates. For example, spending for biomedical research grew at an annual rate of 7.5 percent, compared to 10.2 percent for hospital services and 11.9 percent for physicians' services. Despite these varying rates of growth, patterns of expenditures and sources of funds remained fairly constant through the 1980's. Almost 40 percent of total health care spending is for hospital services, and 20 percent is for physicians' services.[10]

Excluding spending for health by the Department of Defense and the Veterans Administration, more than 10 percent of the Federal budget is spent on health care ($99.4 billion in fiscal year 1985). In comparison, in fiscal year 1965, spending on this portion of the health budget was $1.7 billion, or 1.4 percent of the Federal budget. More than 90 percent of the Federal health budget is spent on the Medicare and Medicaid Programs.

HCFA estimates that health spending for those 65 and older averaged $4,200 per person in 1986, compared with $1,837 per person for all age groups that year. Although persons 65 years of age and older represent approximately 12 percent of the total U.S. population, they account for 31 percent of national expenditures for health care. In 1984, Medicare paid 49 percent of those expenses incurred by the elderly; Medicaid Programs, 13 percent; other public programs, 6 percent (figure 4). The elderly and their families were directly responsible for an estimated 25 percent of the total health care bill. Private, third-party insurers paid the remaining 7 percent.

[9] *Health Care Financing Review*, p. 24.
[10] Anderson and Erickson, pp. 98–99.

FIGURE 4
PERSONAL HEALTH CARE EXPENDITURES FOR THE ELDERLY BY SOURCE OF PAYMENT: 1984



SOURCE: Waldo, Daniel R. and Helen C. Lazenby. "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-1984." *Health Care Financing Review* Vol. 6, No. 1 (Fall 1984).

There is considerable variation in the source of payment depending on the type of service. Public programs paid 89 percent of hospital charges for the elderly in 1984; private funds paid 11 percent. However, private funds paid for 40 percent of expenditures for physician services.[11] While the total share of Medicare Program costs paid by beneficiaries has remained fairly constant over the past 20 years, the portion paid through copayments has increased and the portion paid through premiums has decreased. Today, copayments account for about two-thirds of the costs paid by the elderly.

While the elderly, as a group, consume a disproportionate share of the health dollar, most older persons do not have exorbitantly high medical costs. A large portion of expenditures for health care among older persons is associated with persons who are in their last year of life. In a study completed in 1984, reimbursement and use of services by Medicare enrollees who died in 1978 were compared with those who survived the year. The average reimbursement for those who died was $4,909, which was four times the amount as for those who lived.[12]

---

[11] National Center for Health Statistics, R.J. Havlik, B.M. Liu, M.G. Kovar, et al., "Health Statistics on Older Persons, United States, 1986," *Vital and Health Statistics,* Series 3, No. 25 (Washington, D.C.: GPO, 1987), p. 76.

[12] James Lubitz and Ronald Prihoda, "The Use and Costs of Medicare Services in the Last Two Years of Life," *Health Care Financing Review,* vol. 5, No. 3, Spring, 1984, p. 119.

V. Physician Services and the SMI Program

Utilization of physician services increases with age. Approximately four out of five elderly had at least one contact with a physician in 1983, and more than 16 percent of total physician visits during 1983 were made by persons 65 years of age and older. On average, elderly persons are more likely than younger ones to make frequent visits to a physician. This age group also visits a physician eight times for every five times by the general population. Since the enactment of Medicare, the average number of physician contacts and the percentage of persons 65 and older reporting that they had seen a physician in the last year has increased significantly, particularly for persons with low incomes.[13]

In 1983, 61.9 percent of Medicare approved charges for physicians' services were for care provided on an inpatient basis.[14] Another 29.2 percent were for services provided in physicians' offices, and care given in hospital outpatient settings accounted for 5.9 percent (figure 5). The importance of the inpatient setting in the delivery of physicians' services is illustrated by the following: Physicians in 12 specialties—anesthesiology, thoracic surgery, neurological surgery, general surgery, pathology, pulmonary disease, urology, orthopaedic surgery, cardiology, psychiatry, gastroenterology, and neurology—earned at least two-thirds of their Medicare income in the inpatient setting.[15]

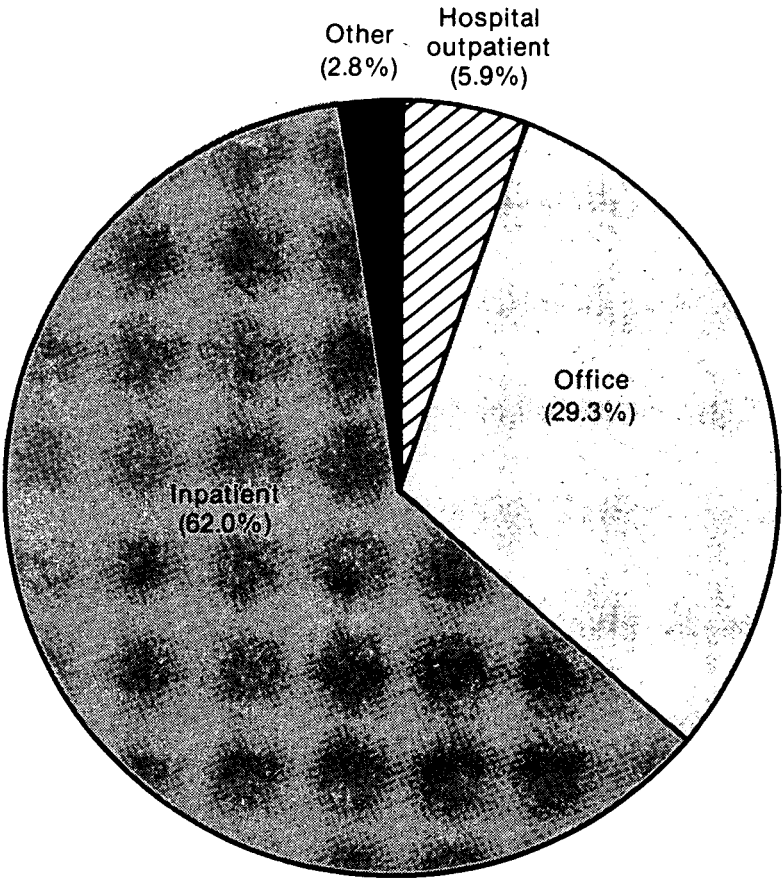
---

[13] U.S. Senate, Special Committee on Aging, *The Health Status and Health Care Needs of Older Americans* (Washington, D.C.: GPO, 1986), p. 26.

[14] Ira Burney and George Schieber, "Medicare Physicians' Services: The Composition of Spending and Assignment Rates," *Health Care Financing Review*, Fall, 1985, vol. 7, No 1, p. 85.

[15] Burney and Schieber, p. 88.

FIGURE 5
PERCENT DISTRIBUTION OF MEDICARE APPROVED CHARGES FOR PHYSICIAN SERVICES BY PLACE OF SERVICE: 1983



SOURCE: Ira Burney and George Schieber, "Medicare Physicians' Services: The Composition of Spending and Assignment Rates," Health Care Financing Review, Fall 1985, 7, no. 1.

(A) MEDICARE PHYSICIAN REIMBURSEMENT

The predominant method of payment for physician services under Medicare is fee-for-service. Payment rates to physicians have been determined through a method referred to as customary, prevailing and reasonable (CPR). Under CPR, the Medicare approved charge is limited to the lowest of:

—the physician's submitted amount—the billed charge;
—the physician's customary charge, equal to the physician's median charge for that service during the previous year; and
—the prevailing charge for the service based on comparable physicians' prior billings for the same service in that locality.

Medicare's approved charges are less than submitted charges for nearly 85 percent of physicians' services billed, because of the effects of the customary and prevailing charge fee "screens" (yardsticks against which charges are compared). Prior to 1984, the screens were updated every July 1.[16] Since 1973, updates in the prevailing charge screens are tied to the Medicare Economic Index (MEI), which reflects general inflation and changes in physicians' practice costs.[17]

The day-to-day functions of reviewing Part B claims and the payment of benefits are conducted by HCFA contractors, called "carriers," who are generally Blue Cross/Blue Shield plans or commercial insurance companies. Typically, carriers do not approve the full amount a physician charges for a service provided to a Medicare patient. In the first quarter of 1985, the average reduction due to the CPR process was 26.2 percent. For example, if a physician submitted a bill for $100, approved charges would average $73.80 (80 percent, or $59.04, would be paid by the carrier). At the end of calendar year 1984, only 18.3 percent of all claims were submitted at or below CPR limits.[18]

(B) DEFINITION OF ASSIGNMENT

Medicare payments are made either directly to the physician or to the beneficiary, depending on whether or not the physician has accepted *assignment* of the claim. For assigned claims, the beneficiary assigns (or transfers) his/her rights to payment from Medicare to the physician. In return, the physician agrees to accept Medicare's "approved" or "reasonable" charge determination as pay-

---

[16] Because the Deficit Reduction Act of 1984 (DEFRA) froze physicians' fees through September 30, 1985, the annual increases in the customary and prevailing charge screens slated for July 1, 1984, did not occur. Subsequent fee screen updates were scheduled to occur October 1 of future years beginning in 1985. However, the increase slated to occur on October 1, 1985, was postponed by the Temporary Extension Act of 1985 and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, the next update occurred on May 1, 1986, for participating physicians only. Updates for all physicians occurred on January 1, 1987; updates for 1988 occurred on April 1, 1988. Prevailing charges for nonparticipating physicians will continue to be less than those for participating physicians.

[17] The MEI was established by the Social Security Act of 1972 (Public Law 92-603) to set an annual cap on prevailing charges. Prevailing charges are now either the lesser of the "unadjusted" prevailing charge or the product of the 1973 fee screen year multiplied by the value of the current MEI. For example, the MEI in 1983 was 2.063. If a prevailing charge for a certain service was $10 in 1973, and if the "unadjusted" prevailing charge was not less than $20.63 in 1983, the prevailing charge for 1983 would be $20.63 (the "adjusted" prevailing). However, if the charge for this service in 1983 were $20 (or any other amount less than $20.63), the prevailing charge would be $20.

[18] Health Care Financing Administration, Bureau of Quality Control, *Carrier Reasonable Charge and Denial Activity Report, January–March 1985* (Washington, D.C.: GPO, 1985), p. 165.

ment in full for covered services. The physician bills the program directly and is paid an amount equal to 80 percent of Medicare's reasonable or approved charge. The patient is liable for the 20 percent coinsurance. The physician may not charge the beneficiary (nor can he/she collect from another party such as a private insurer) more than the applicable deductible and coinsurance amounts if he/she agrees to accept assignment. The beneficiary is then protected against "balance billing," that is, the difference between Medicare's approved charge and the physician's actual charge. In 1986, 69.5 percent of claims were paid on an assignment basis.

A physician (except a "participating physician") may accept or refuse requests for assignment on a bill-by-bill basis, from different patients at different times, or from the same patient at different times. However, he/she is not permitted to "fragment" bills for the purpose of circumventing the reasonable charge limitation, and must either accept assignment or bill the patient for all of the services performed on a single occasion.

Whether or not a claim is "assigned" affects beneficiaries' out-of-pocket liabilities for Medicare-covered services. For example, in the first quarter of 1985, the average billed claim for physicians who accepted assignment was $122.35; the average for nonassigned claims was $128.93. Of the assigned claims, 81.6 were subject to reductions which averaged $32.48 per claim, resulting in allowed charges of 73.5 percent per assigned claim, or $89.92 (73.5 percent $\times$ $122.35=$89.92). Of non-assigned claims, 84.7 percent were subject to reductions averaging $32.84 per claim, yielding allowed charges equal on average to 74.5 percent, or $96.05 (74.5 percent $\times$ $128.93=$96.05).[19] Therefore, for claims subject to CPR reductions, expected beneficiary out-of-pocket cost was $17.98 (20 percent coinsurance $\times$ $89.92=$17.98) per *assigned claim.* However, for *nonassigned* claims, the coinsurance cost of $19.21 (20 percent $\times$ $96.05=$19.21) plus the nonassigned liability of $32.84 equals an expected out-of-pocket cost of $52.05, a difference of 289 percent.

There has been a general upward trend in assignment rates since fiscal year 1979, from 50.9 percent that year to 69.5 percent in 1986. Assignment rates vary according to a beneficiary's age and race. In 1982, when the acceptance of assignment for charges was 52 percent overall, rates ranged from 47 percent of the young-old (ages 65–69) to 61 percent of the old-old (age 85 and older). Rates for women and men were about the same, about 50 percent. Assignment rates for non-white beneficiaries were 80 percent, compared to 49 percent for whites.[20]

Assignment rates also vary greatly depending on geographic location and type of service or specialty. During the first quarter of 1987, assignment rates varied from 24.2 percent in Idaho to 95 percent in Rhode Island to 98.1 percent in Massachusetts (although Massachusetts law requires that all physicians accept assignment for services rendered to Medicare patients). Differences also exist

---

[19] *Carrier Reasonable Charge and Denial Activity Report, January-March 1985,* as cited in *Payment for Physician Services,* U.S. Congress, Office of Technology Assessment (Washington, D.C.: GPO 1986), p. 58.

[20] Alma McMillan, James Lubitz, and Michael Newton, "Trends in Physician Assignment Rates for Medicare Services, 1965–1985," *Health Care Financing Review,* vol. 7, No. 2, Winter, 1985, p. 65.

in assignment rates among the various physician specialties, although they are not quite so dramatic as those among States. In 1985, they ranged from 51 percent for anesthesiology to 81 percent for psychiatry. Primary care specialties have a lower assignment rate than medical subspecialties (figure 6).

FIGURE 6
PHYSICIAN ASSIGNMENT, PARTICIPATION AND CHARGE REDUCTION RATES BY SPECIALTY (IN PERCENT)

Specialty	Assignment Rate 1985	Participation Rate 1987	Charge Reduction Rate 1983
Anesthesiology	51	20.3	38.2
Cardiology	67	43.2	23.5
Dermatology	64	38.1	19.5
Family Practice	60	27.1	23.6
Gastroenterology	74	n.a.	20.5
General Practice	59	25.6	23.9
General Surgery	73	37.2	26.1
Internal Medicine	62	33.6	22.6
Neurological Surgery	57	n.a.	32.0
Neurology	67	37.2	28.3
Obstetrics-Gynecology	54	31.5	n.a.
Ophthalmology	65	35.1	21.2
Orthopedic Surgery	55	32.6	27.1
Otolaryngology	56	27.0	27.3
Pathology	69	41.2	29.4
Psychiatry	81	28.6	32.4
Radiology	69	39.8	22.0
Thoracic Surgery	68	n.a.	23.3
Urology	55	30.7	25.0

Sources: BMAD 5 Percent Beneficiary File, unpublished data from HCFA, Bureau of Program Operations, HCFA 5 Percent Sample of Bill Summary Records

Surgical procedures are more likely to be rendered on an assigned basis than are medical services, and those services delivered in an inpatient setting are more likely to be assigned than those in a physician's office. Because surgical and inpatient procedures are generally more expensive, this has a significant impact on beneficiary out-of-pocket costs. In 1985, hospital inpatient and outpatient assignment rates averaged 68 percent and 63 percent, respectively, compared with 51 percent for services delivered in physicians' offices.

(C) THE PARTICIPATING PHYSICIAN PROGRAM

The Medicare participating physician program was established by the Deficit Reduction Act of 1984 (Public Law 98-369), or DEFRA, and took effect October 1, 1984. A physician who enters

into a voluntary agreement with HCFA to accept assignment for *all* services provided to *all* Medicare patients for a specified period, usually 12 months, is a *"participating physician."* A nonparticipating physician is a physician who has not signed a voluntary participation agreement. A nonparticipating physician may accept assignment on a case-by-case basis.

There are a number of incentives designed to encourage physicians to become participating physicians. During the fee freeze, also imposed by DEFRA as an interim measure to control physician expenditures, participating physicians were permitted to increase their billed charges. Although these increases did not affect payments made to participating physicians during the freeze, they were reflected in the calculation of customary charge screen updates. The freeze was lifted for participating physicians on May 1, 1986, and these physicians received an increase of 4.15 percent in their maximum allowable prevailing charges. Nonparticipating physicians were subject to the freeze until January 1, 1987. During the entire freeze period, nonparticipating physicians could not raise their actual charges above the levels charged during April–June, 1984. As a result, there are two prevailing charge levels for physicians in any locality—one for participating physicians and another lower one for nonparticipating physicians. All physicians received an increase of 3.2 percent in their maximum allowable prevailing charge charges, effective January 1, 1987.

Nonparticipating physicians are subject to a limit on their actual charges. This is referred to as the maximum allowable actual charge, or MAAC. Nonparticipating physicians whose actual charge for a service in the preceding year equals or exceeds 115 percent of the current year's prevailing charge, can increase their actual charges by 1 percent. Those whose actual charge for the preceding year is below 115 percent are also subject to a limit. They can increase their actual charge over a 4-year period so that in the fourth year the actual charge equals 115 percent of the prevailing charge. The MAAC for a nonparticipating physician whose actual charge for a service in the previous year is less than 115 percent of the current year actual charge is the dollar amount which is the greater of:

(1) the amount 1 percent above the physician's previous year's actual charge; or

(2) an amount based on a comparison between the physician's MAAC for the previous year and 115 percent of the current prevailing charge.

Under (2), the MAAC for the current year equals the previous year MAAC increased by a fraction of the difference between 115 percent of the current year prevailing charge and the previous year MAAC. The applicable fractions are one-quarter, one-third, one-half, and one for 1987, 1988, 1989, and 1990, respectively. For example, if a physician's 1986 MAAC for a service is $100, and 115 percent of the 1987 prevailing charge amount is $124, the 1987 MAAC for the physician for that service is $106 [$100 + 0.25($124 − $100)].

Since the participating physician program was begun in 1984, participation rates have been fairly constant (about 30 percent). However, in the period from April 1 to December 31, 1988, partici-

pation rates rose to 37.3 percent, an increase of 21 percent. Rates vary dramatically across the country—from a high of 73.5 percent in Alabama to a low of 14.9 percent in Idaho. Likely causes for the increase include varied efforts and incentives by HCFA to make participation in the Medicare Program attractive to physicians, such as higher reimbursement rates and fewer administrative and paperwork requirements. The lower participation rates in Idaho and other States such as South Dakota (17.6 percent) and Wyoming (20.1 percent) are possibly a result of the more conservative nature of those States, or, in the words of the executive director of the Idaho Medical Association, a reflection of "a perception that reimbursement in this area of the country is too low in relation to other areas."[21]

(D) PHYSICIAN INCOME

Physician incomes have been increasing over the past several years. In 1986, net incomes averaged $119,500, more than double the 1975 level. After adjusting for inflation, physicians' average net income rose by 6 percent between 1975 and 1986, although the average income for all full-time, year-round workers in the United States showed little or no growth. Consequently, physicians' average income increased from 4.4 times that of an average employee in 1975 to 4.6 times that in 1986.[22]

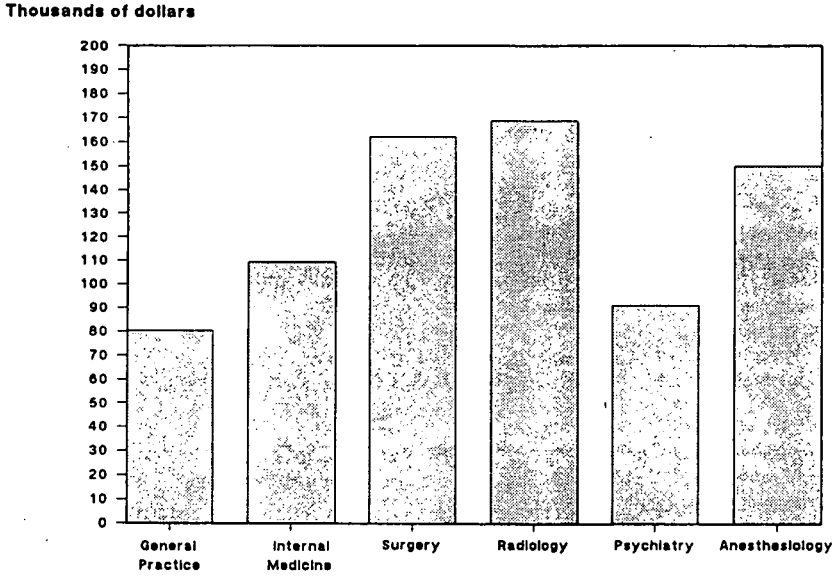
There is considerable difference in income among the various physician specialties. Surgeons, radiologists, and anesthesiologists had the highest average incomes in 1987; pediatricians, general and family practitioners, and psychiatrists had the lowest (figure 7). Surgeons average income of $162,400 in 1987 was 36 percent above the average compensation for all physicians. Substantial variation also exists in incomes depending on geographic region. In 1987, net income varied by census division from an average of $107,000 in New England to $129,000 for the West South Central area. Income in nonmetropolitan areas was $107,000. In metropolitan areas with populations under 1 million, average net income was $124,500, and $117,500 in metropolitan areas with populations over 1 million.[23]

[21] Sharon McIlrath, "Participation MD Rate Jumps 21%," *American Medical News,* August 5, 1988, p. 1.

[22] American Medical Association, *Socioeconomic Characteristics of Medical Practice 1987,* M.L. Gonzalez and D.W. Emmons, eds., (Chicago: American Medical Association).

[23] American Medical Association.

FIGURE 7
AVERAGE PHYSICIAN BEFORE-TAX NET INCOME
BY SPECIALTY: 1986



Source: AMA Socioeconomic Monitoring System.

Medicare's contributions to physicians' income also varies widely by specialty, and is concentrated in certain specialties. In 1983, internal medicine accounted for the largest share of Medicare approved charges for physicians' services—19.7 percent. The top five specialties under Medicare—internal medicine, ophthalmology, general surgery, radiology, and general practice—accounted for 52.6 percent of Medicare approved charges for physicians' services that year. Medicare approved charges averaged $34,056 per physician in 1983. However, in five specialties—thoracic surgery, ophthalmology, radiology, urology, and cardiology—Medicare approved charges averaged more than $75,000 per physician.

VI. Problems With the Current Physician Reimbursement System

Even with the CPR limits, Part B approved charges per aged Medicare enrollee increased by 591 percent between fiscal year 1968 and fiscal year 1983. In fiscal year 1984, Medicare carriers possessed 229 million Part B claims, or approximately 7 claims per enrollee. Total claims volume has grown at an average annual rate of 12.6 percent since 1968. Annual growth in claims per enrollee

has averaged 9.4 percent.[24] From 1976 to 1982, expenditures for physician services for the elderly have increased 18 percent per year—2 percent from enrollment increases, 10 percent from price increases, and 6 percent in the number of services per enrollee.[25] Most of the expenditures for physician services are for those provided in the hospital (61.9 percent in 1983). With few exceptions, most specialties have higher total billings for services provided in the hospital than in an office.

The CPR system has been criticized for providing little, if any, incentive for physicians to deliver cost-effective care. Controls on both volume and price must be in place if expenditures are to be kept in check, and CPR provides neither. As originally designed, the CPR method had inherent inflationary tendencies because physicians' maximum allowable payment levels were based, in part, on their actual charges in the previous 12-month period. As a result, they had an incentive to increase current charges to increase future charges. This incentive has been somewhat moderated by the use of the Medicare Economic Index in determining increases in fee screens.

Further, because CPR reimburses on a fee-for-service basis, physicians are encouraged to increase the number of services provided to beneficiaries. Although offset by some degree by concern about patients' out-of-pocket costs, physicians face incentives under CPR to provide all services of any potential benefit to their patients so long as their reimbursement is high enough to offset the cost of providing the service.

Beneficiaries are insulated to a degree from rising costs because of the prevalence of supplemental medigap insurance coverage. Some 70 percent of Medicare enrollees are covered by some form of supplemental health insurance which generally pays the deductibles and copayments for Medicare approved charges.

The growth in volume of services can be attributed to a number of factors. The number of physicians per capita has been increasing over the past several years, which has resulted in a reduction in the average patient load. There is some evidence that physicians with relatively low patient loads may provide more intensive and therefore more costly care (e.g., more tests, more follow-up visits, etc.) than those physicians with a higher patient load.[26] In addition, physicians may tend to increase the volume of services for which they bill in response to limitations on reimbursement, as have occurred under the Medicare Program. Further, many contend that the growing threat of malpractice suits has forced physicians to practice "defensive medicine" and provide more services than might otherwise be necessary in order to protect themselves.

Not all the growth in the volume of services provided is undesirable, however. The average age of the Medicare population has been increasing, and the need for medical services typically in-

---

[24] U.S. Congress, Office of Technology Assessment, *Payment for Physician Services: Strategies for Medicare*, OTA-H-294 (Washington, D.C.: GPO, 1986), p. 41.

[25] Lynn Etheredge and David Juba, "Medicare Payments for Physicians' Services," *Health Affairs*, Winter, 1984, vol. 3, No. 4, p. 132.

[26] Gail R. Wilensky and Louis F. Rossiter, "The Relative Importance of Physician-Induced Demand in the Demand for Medical Care," *Milbank Memorial Fund Quarterly*, Spring, 1983, p. 256.

creases with age. Additionally, there have been tremendous technological advances made in recent years such as improved techniques for cataracts, and in procedures for the replacement of major joints (e.g., hip replacement). These advances have enabled physicians to respond more effectively to the health care needs of their patients.

The use of an individual service as the payment unit is another problem under CPR. Physicians can bill separately for an initial visit, any follow-up visit, and for each individual lab test or X-ray procedure performed. It can be argued that this provides an incentive to physicians to provide additional services. A related problem is known as "unbundling" in which services previously billed as one unit are billed separately. This problem has been cited as one of the more significant contributors to inflation in physician expenditures.

Coding policies are also considered somewhat inflationary. Procedure codes for some high volume services such as office visits are not precisely defined. It may therefore be possible to describe the same service by a code with a higher allowable charge. A "brief visit" may become an "intermediate visit." This phenomenon has been called "code creep" or "upcoding." There is also some discussion as to whether the increased number of individual procedure codes (rising from 2,000–2,500 in 1966 to over 6,000 today) may also facilitate code creep.

Another common criticism of the current reimbursement system is that its complexity makes it extremely difficult for both physicians and their patients to understand. Even with the participating physician program, it is still difficult for beneficiaries to estimate the amount of his or her out-of-pocket liability for Medicare-covered services.

Medicare beneficiaries who are still employed may also be a source of uncertainty and confusion for providers. Medicare is not the primary payer for aged beneficiaries under age 70 who are covered by employer-sponsored health insurance. A physician who treats such a beneficiary may discover that the charge approved by the patient's insurer is not the same as the Medicare allowed charge. Also, if the physician accepted assignment and submitted the bill to the Medicare carrier, Medicare might deny payment unless it had first been submitted to the patient's primary insurer.

(A) GEOGRAPHIC VARIATION IN REIMBURSEMENT

There is substantial geographic variation in aspects of Medicare payment, including assignment rates, annual expenditures per beneficiary, and reimbursement rates for certain services. There is little agreement as to how much of this variation can be attributed to expected differences in serving over 30 million enrollees in thousands of different markets, and problems regarding access, quality, and efficiency.[27]

Among Medicare's 240 charge areas, three- and four-fold differences in charges for particular procedures are common. Even within one State, charges vary widely from area to area. In Texas, a large State with a number of charge areas, the highest prevailing

[27] Office of Technology Assessment, p. 6.

charge for a general practitioner's follow-up hospital visit in 1984 was approximately 2.5 times greater than the lowest.[28]

Payment rates for physician services tend to be higher in metropolitan than in rural areas, but these differences are not always uniform. In New York and Illinois, for example, charges in metropolitan areas exceeded those in nonmetropolitan areas by at least 28 percent. However, in Rhode Island and Connecticut, prevailing charges in nonmetropolitan counties exceeded those in metropolitan areas.

There is also tremendous variation by carrier jurisdiction (in 1984, there were 58 jurisdictions administered by 40 carriers) in Medicare expenditures per enrollee for physician and other medical services. This variation depends on the proportion of beneficiaries who exceed the Medicare deductible and are then eligible for reimbursement. That number, in turn, depends on variations in health, volume of services, physicians' charges, and the Medicare carriers determination of approved charges.[29]

(B) NONPROCEDURAL AND PROCEDURAL FEE DIFFERENTIALS

There appears to be significant differences in the relative approved charges for "procedural" or medical services, which utilize medical devices and equipment, and are usually hospital-based, and "nonprocedural" services, such as office visits. In other words, under the current system, a physician can generate more income by providing laboratory tests or interpreting an EKG than he or she can giving advice on nutrition or the benefits of exercise. This raises some concerns about the incentives in the current system that encourage the use of services which not only command high fees but also consume large amounts of support and technical resources. Similarly, the system may discourage physicians from spending time with patients to counsel or examine them.

There is a growing body of research on this issue of the relative values of various physicians' services. This approach will likely be the basis for reform of the current Medicare physician reimbursement system, which is discussed later in this report. A 1979 study by William Hsaio and William Stason focused on the professional time expended and the complexity of the service rendered.[30] After standardizing for complexity among selected procedures, the study showed that physicians were paid as much as four to five times more per hour for hospital-based surgery than for office visits. A follow-up study using 1983 data showed that values of surgical procedures relative to office visits are, at minimum, two or three times higher when calculated on the basis of charges than when calculated from resource inputs.

(C) INHERENT REASONABLENESS

Physicians' fees for new services are often set at a high level to reflect the fact that they may require special skills or a substantial amount of the physician's time to perform. However, as the provi-

---

[28] Office of Technology Assessment, pp. 6–7.
[29] Office of Technology Assessment, p. 6.
[30] William Hsaio and William Stason, "Toward Developing a Relative Value Scale for Medical and Surgical Services," *Health Care Financing Review,* Fall, 1979, p. 27.

sion of these services becomes more commonplace, and increased experience, higher volume, and technological changes have actually lowered costs, there is often not an accompanying reduction in the reimbursement rates. A frequently cited example is that of coronary bypass surgery. Although it is now a common procedure (50,000 reimbursed under Medicare in 1982), its charges have remained fairly high. Medicare carriers have the authority to use factors other than CPR in determining whether a charge for a specific service is inherently reasonable. This is discussed in greater detail below in the section on legislation.

(D) SPECIALTY VARIATIONS

Considerable variation exists in fees recognized by the Medicare Program for certain medical services performed by physicians in general practice as opposed to fees for similar services performed by specialists. In the 1984 fee screen year (July 1, 1983–June 30, 1984), Medicare carriers recognized specialty reimbursement differentials in nearly every area in the country. The differentials were originally intended to reflect the fact that specialists may provide a different type or higher quality service. There is concern, however, that the differences in fees may not be warranted and have in fact resulted in increased specialization. Many contend that Medicare is paying more for comparable services. For example, in fee screen year 1984, the mean prevailing charge for specialists was 16 percent higher than for generalists for a "brief follow-up hospital visit" and 24 percent higher for a "brief follow-up office visit."

Neither Medicare nor the medical community has established a single uniform definition of "specialist." A 1984 report from the General Accounting Office (GAO) reviewed how carriers determined reimbursement rates among the various physician specialists. GAO identified several problem areas.[31] The report found that HCFA had given Medicare carriers little guidance in determining whether specialty recognition was warranted for particular procedures. Further, Medicare law requires carriers to compare charging patterns among physician specialties to determine if those patterns show a basis for establishing separate prevailing rates for the same procedure. The carriers that GAO reviewed, however, had made little or no analysis in support of either multiple or prevailing rates.

GAO discovered wide variation in the way carriers recognize specialties in establishing prevailing rates. Some carriers did not recognize any specialties and had only one prevailing rate for a particular procedure; others developed prevailing charges for each specialty individually; still others combined numerous specialties into several prevailing rate groups. Of the 11 carriers that GAO reviewed for their study, 2 recognized 31 different prevailing rates, while 3 carriers recognized only 1 (figure 8).

---

[31] U.S. Congress, General Accounting Office, *Reimbursing Physicians Under Medicare on the Basis of Their Specialty*, report to the Health Care Financing Administration, GAO/HRD 84-94 (Washington, DC: Sept. 27, 1984).

FIGURE 8
NUMBER OF PREVAILING RATES BY CARRIER: 1984

Carrier and State	Number
Nationwide (Ohio and West Virginia)	31
Blue Cross and Blue Shield of South Carolina	31
Blue Cross and Blue Shield of Colorado	30
New Hampshire-Vermont Health Services	30
Blue Shield of Massachusetts[a]	25
Prudential Insurance Co. of America (Georgia)	23
CIGNA (Connecticut)	3
The Equitable Life Assurance Society of the United States (Wyoming)	2
Blue Cross and Blue Shield of Florida	1
Blue Cross and Blue Shield of North Dakota	1
Blue Cross and Blue Shield of Michigan	1

Source: General Accounting Office, 1984

The report noted that the use of more than one prevailing rate could lead to significant variations among specialties. For example, for the 1981 fee screen year, the prevailing rate for a "consultation requiring a comprehensive history" in urban areas of Massachusetts ranged from $40 for a general practitioner to $89.50 for a cardiologist or pulmonary disease specialist.

The report also reviewed the practice of "self-designation" in which a physician classifed himself or herself as a specialist regardless of education, training, experience, etc. In a review of three carriers, it was found that approximately one-half of the physicians who self-designated specialties were not board-certified in that specialty. Further, roughly one-fourth of the physicians who designated subspecialties in internal medicine were not even board-certified in internal medicine.

VII. Recent Legislation

Recent legislation, beginning with the enactment of Public Law 98-369, the Deficit Reduction Act of 1984 (DEFRA), has made numerous modifications in the physician payment provisions of Medicare. Because the pertinent provisions of DEFRA—the establishment of the participating physicians program and the implementation of the fee freeze—have been examined earlier in this report, discussion of DEFRA will be somewhat limited. This section will focus on provisions within the three subsequent budget reconciliation bills: Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA); Public Law 99-509, the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986); and Public Law 100-203, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).

(A) DEFRA

Under DEFRA, Congress implemented a 15-month freeze on physician fees effective July 1, 1984 to September 30, 1985. Consequently, the annual updating of customary and prevailing charge screens did not occur, and subsequent updates were slated to occur on October 1 of future years beginning in 1985. No catch-up would be permitted to account for any economic index increase to the prevailing charge screen that would otherwise have occurred during the freeze period. (The freeze was extended several times, and was finally lifted for participating physicians on May 1, 1986, and for nonparticipating physicians on January 1, 1987). DEFRA also established the participating physicians program which is discussed earlier in this paper.

(B) COBRA

COBRA, signed into law in April 1986, made several significant modifications to the physician reimbursement system under Medicare. In April 1986, physicians were given the opportunity to change their participation status for the 8-month period beginning May 1, 1986. Future update and payment cycles would begin on January 1 of each year, beginning in 1987.

Physicians covered under participation agreements on May 1, 1986, received updates in their customary and prevailing charges. Physicians who participated in fiscal year 1985 but not for the period beginning May 1, 1986, had their customary charges updated. For physicians participating in neither period, the existing freeze on customary and prevailing charges was extended through December 31, 1986. The freeze on actual charges was extended for all nonparticipating physicians for the same period.

The customary and prevailing charge screen updates scheduled to occur October 1, 1985, began on May 1, 1986. To compensate participating physicians for the delay, the MEI was increased by 1 percentage point. However, this increase was not built permanently into the prevailing charge levels. COBRA also provided that nonparticipating physicians would be subject to the prevailing charge limits applied to participating physicians during the preceding participation period (later modified by OBRA, discussed below).

COBRA established an independent Physician Payment Review Commission to make recommendations regarding Medicare physician payments. It also required the Secretary of DHHS, with the advice of the Commission, to develop a relative value scale (RVS) for physician payments. The development of the RVS was to be completed by July 1, 1987, and recommendations concerning its application to Medicare be made on or after January 1, 1988. (See OBRA for modification.)

Medicare law has permitted the Secretary of DHHS to use "other factors that may be found necessary and appropriate with respect to a particular item or service . . . in judging whether the charge is *inherently reasonable* [emphasis added]." These factors include: Increases in charges that cannot be explained by inflation or technology; prevailing charges for a service which are substantially higher or lower than payments by other purchasers in the same locality or in other comparable localities; Medicare or Medicaid as

the sole or primary payer; or the marketplace is not truly competitive. Under COBRA, the Secretary is required to promulgate regulations specifying explicitly the criteria of "inherent reasonableness" that are to be used for determining Medicare payments.

(C) OBRA 1986

OBRA lifted the fee freeze on nonparticipating physicians, effective January 1, 1987 (the freeze for participating physicians had been lifted as of May 12, 1986). Beginning in 1987, all participating and nonparticipating physicians received an increase in their prevailing charge levels, above those in effect for the previous period, equal to 3.2 percent. In 1988 and future years, prevailing charges will be increased by the percentage increase in the MEI, and the 1 percent increase in the MEI enacted by COBRA would be built into the base for future calculations. OBRA also established maximum allowable actual charges (MAAC's) for nonparticipating physicians. It also contained a number of provisions aimed at encouraging physicians to become participating physicians such as education of beneficiaries on the program, and incentives directed at carriers to recruit participating physicians.

In response to inherent reasonableness provisions in COBRA, DHHS promulgated regulations with regard to cataract surgery in order to reduce Medicare payment for these services. Because of strong objections by the medical community, Congress responded with a new plan, and these regulations were superseded by provisions in OBRA. Under OBRA, the Secretary of DHHS is authorized under the inherent reasonableness authority to establish a payment level for physicians' services based on criteria other than the actual, customary, and reasonable charge for the service. Specific criteria and procedures for adjusting the payment levels are prescribed. The Secretary is also required to review, by October 1, 1987, the inherent reasonableness of payments for 10 of the most costly procedures paid for under Part B. This law reduced by 10 percent the prevailing charges for cataract surgery procedures performed in 1987, and by 2 percent in 1988. In no case could the reduced prevailing charge be lower than 75 percent of the national average prevailing charge.

OBRA also defers the date that the Secretary is required to report on the RVS to July 1, 1989, and the potential application date of the RVS is deferred until after December 31, 1989. OBRA also requires the Secretary to take geographic factors, such as practice costs and distribution of physicians, into consideration in making recommendations for the application of an RVS.

Finally, OBRA required the Secretary to study and report to Congress by July 31, 1987, concerning the design and implementation of a prospective payment system for payment under Part B for radiology, anesthesiology, and pathology (RAP) services furnished to hospital inpatients.

(D) OBRA 1987

OBRA 1987 contained several provisions to limit physician expenditures under Part B of the Medicare Program. During the 3-month period ending March 31, 1988, prevailing and customary

charge levels will be maintained at the levels in effect during 1987. A 2.3 percent reduction in Medicare payments to physicians that was initially put into place through the Gramm-Rudman sequestration process on November 20, 1987, was extended through March 31, 1988. Effective April 1, 1988, the increase in the MEI for participating physicians will be 3.6 percent for primary care services (e.g., home and office visits, emergency department services) and 1 percent for other physician services. Nonparticipating physicians will receive an increase of 3.1 percent for primary care services and 0.5 percent for other services.

In 1989, the percentage increase in the MEI for participating physicians will be 3 percent for primary care services and 1 percent for other services. The MEI increase for nonparticipating physicians will be 2.5 percent and 0.5 percent, respectively. By January 1, 1989, the prevailing charge differential between participating and nonparticipating physicians will be 5 percent.

The Secretary of DHHS will be authorized to monitor the actual charges of each nonparticipating physician for services provided after March 31, 1988. Where a physician knowingly and willfully bills for a service on a repeated basis an actual charge in excess of the MAAC, the Secretary will be authorized to apply sanctions.

OBRA 1987 specifies that effective April 1, 1988, the following 12 physicians' services will be subject to "reasonable charge" reductions: bronchoscopy, carpal tunnel repair, cataract surgery, coronary artery bypass surgery, diagnostic and/or therapeutic dilation and curettage, knee arthroscopy, knee arthroplasty, pacemaker implantation surgery, total hip replacement, suprapubic prostatecetomy, transuretheral resection of the prostate, and upper gastrointestinal endoscopy.

The 1987 prevailing charge levels will be reduced initially by 2 percent, and further reductions of up to 15 percent will be implemented pursuant to a sliding fee scale. Prevailing charge levels that are at or above 150 percent of the weighted national average of prevailing charges for the procedure in all localities in the United States for 1987 will be reduced by 15 percent. Where the physician's prevailing charge level for the service does not exceed 85 percent of the weighted national average, there will be no reduction beyond the 2 percent previously mentioned. Where prevailing charge levels are between 85 percent and 150 percent of the weighted national average, the percentage reduction will be based on a straight line sliding fee scale equal to 3/13 of a percentage point for each percent by which the prevailing charge exceeds 85 percent of the weighted national average. In setting the new prevailing charge levels for these services, the Secretary's determination will not be subject to administrative or judicial review.

OBRA 1987 contained several other provisions that affect physicians and physician reimbursement under Medicare. A provision to give incentive payments to physicians providing services in rural and/or medically underserved areas is of particular importance to Medicare beneficiaries experiencing problems with access to health care. An additional payment equal to 5 percent of the allowed amount for services will be made starting January 1, 1989, for services provided in a rural area, and on January 1, 1991, for services provided in a nonrural health manpower shortage area.

The Reagan administration's fiscal year 1988 budget proposal would have modified the fee-for-service reimbursement system for radiology, anesthesiology, and pathology (RAP) services provided for hospital inpatients. Under this proposal, Medicare would have paid an average rate per discharge for all RAP services, similar to DRG's. Congress rejected the administration's plan; however, certain provisions within OBRA 1987 address these issues. The law reduces payments for anesthesiologists supervising certified registered nurse anesthetists, and requires the Secretary of DHHS to develop an RVS to serve as the basis of payment for physician radiology and pathology services. The Secretary is to use the RVS and appropriate conversion factors in developing proposed fee schedules by August 1, 1988, for radiology services, and by January 1, 1990, for pathology services.

While several of the provisions in OBRA 1987 and preceding legislation that address the issue of physician payment reform are somewhat short-term or limited in nature, they nonetheless represent a movement toward more fundamental change. Because reform of the current system is an issue that Congress, the administration, aging advocacy organizations, and other policymakers basically agree upon, finding and implementing solutions will likely occur more readily than if it were a politically contentious issue. A new administration in the White House in 1989, regardless of the political party, will likely add impetus to the current movement toward reform. Many observers believe that a new reimbursement system could be in place by the early 1990's.

VIII. Physician Payment Reform Options

Neither the fee freeze nor the participating physicians program are considered to be a long-term solutions to controlling expenditures in the Part B program. Serious consideration of more fundamental reforms has been hampered by several factors. These include major gaps in the data on what the program is currently paying for, oppositions by physician groups to a major alteration in the fee-for-service and voluntary assignment approach, and the uncertainty of the impact of the major reform options on both the program and its beneficiaries. However, with the increasing need to curb costs and the vast innovation and change occurring in the organization of physician practice, pressures for comprehensive reform are likely to mount.

The major alternatives which are being considered include:

1. Payment based on a fee schedule, which would be developed using a "relative value scale" (RVS). An RVS gives each service a weight, which would be multiplied by a "conversion factor" stated in dollars. This approach would help the Federal Government to assess the value of services relative to one another.

2. Payment for packages of services, which is a DRG-type approach. Medicare would pay a predetermined amount for a "bundle" of physician services depending on the diagnosis.

3. Capitation payment, in which Medicare would contract with individual providers, hospitals, health maintenance orga-

nizations, etc., to provide all services to Medicare beneficaries for a fixed amount per year.

4. Modifying the current fee-for-service system, limiting payments made to physicians, and adjusting the relative payment levels resulting from geographic differences, specialties, etc.

Studies of a number of options are currently being conducted by HCFA and other public and private entities. The Physician Payment Review Commission (PPRC), established by COBRA, released its first report to Congress in March 1987, and its second report in March 1988. The first report endorsed the concept of a fee schedule based on an RVS scale as the primary method of paying physicians. The second report is even more specific: It recommends that the basis of the RVS should be resource costs. DHHS received the resource-based RVS it requested from researchers at Harvard University in September 1988 (discussed below). In February 1986, the Office of Technology Assessment (OTA) released its major study on physician payment options.[32] OTA's report, along with the work of PPRC and others, has helped to form the debate as Congress continues to review possibilities for comprehensive reform. Following is a more detailed discussion of the various payment reform options under consideration.

(A) FEE SCHEDULES

Under this approach, the current de facto fee schedules based on local prevailing charging patterns would be replaced by a uniform fee schedule for all physicians' services. This could be accomplished through the use of a relative value scale, which is a method of valuing individual services in relationship to each other. Each service is assigned an abstract index or weight and other services are assigned higher or lower numbers to indicate their value relative to that service. An RVS based on resource costs could make the payment system more sensitive to a physician's time, skill, overhead costs, and the complexity of the service. An RVS is not a fee schedule. However, it is translated into a fee schedule by use of a predetermined conversion factor. The drawback to RVS is that its complexity is such that a workable system may be difficult to develop.

The discussion surrounding the resource-based relative value scale has centered on that developed by Professor William Hsaio and others at the School of Public Health at Harvard University. Their congressionally mandated report was released to HCFA on September 29, 1988. The Harvard researchers found that the current reimbursement system pays too much for surgical services and too little for cognitive services. Preliminary assessment of the income redistribution that would result under this RVS revealed that Medicare revenues for family physicians could increase as much as 60 to 70 percent, while thoracic surgeons and ophthalmologists could see their Medicare revenues decrease 40 to 50 percent.

With funding from HCFA, the Harvard researchers surveyed 180 physicians in each of 12 specialties that have high numbers of physicians and consume a large portion of Medicare physician expenditures. These specialties were: anesthesiology, family practice, inter-

[32] Office of Technology Assessment, p. 54.

nal medicine, obstetrics/gynecology, ophthalmology, orthopedic surgery, otolaryngology, pathology, radiology, general surgery, thoracic/cardiovascular surgery, and urology. Researchers selected procedures and then ranked them according to mental effort required to perform the service; technical skill; physical effort; psychological stress due to uncertainty; and potential risk to patient or physician. It was their intent to assign a worth, or value, to the intensity of effort associated with each service. Although the researchers were not able to evaluate variations in physician competence and patient characteristics, they believe their margin of error to be only 5 percent to 10 percent.

The results of the Hsaio study will likely meet with mixed reactions from various physician specialty groups. For example, the study supports previous findings that Medicare overpays cataract surgery by about 63 percent. On the other hand, the study found that family practitioners and internists are being underpaid by Medicare. The American Medical Association (AMA) supports the Harvard project as a way "to establish some sort of benchmark." However, the AMA also states that "in no way should it be considered a fixed, mandatory reimbursement policy." [33]

PPRC faces a difficult task in translating the Harvard RVS—or any RVS—into a workable Medicare fee schedule. Among the stumbling blocks they must overcome is adjusting rates to reflect geographic variation in practice costs, such as office rents, personnel, and professional liability insurance. However, measuring these variations is fairly straightforward, and PPRC is currently involved in developing methods to address these variations.

Widely varying regional specialty differentials in Medicare payments would be eliminated through the development of a uniform national policy for specialty differentials. PPRC's approach to this is to make Medicare reimbursement for a particular service the same for all physicians, regardless of specialty, if the service provided is essentially the same. However, substantial evidence exists that physicians with different specialties see different types of patients or have different approaches to their care, or both. Where specialty differentials are required, PPRC believes its magnitude should be based on resource costs—which include the time and intensity of the physicians' efforts and overhead expenses.

Coding is yet another issue that PPRC must address. An ambiguous coding system that is interpreted differently by various providers and payers makes it difficult to assign accurate relative values to codes and to ensure that assigned fees are applied to the intended services. The Commission is working to make the interpretation of codes more uniform under the fee schedule. For example, in the case of surgical services, this can be accomplished by standardizing carrier interpretation and implementation of current codes. PPRC is using a panel of physicians from various specialties to develop a generic description of "global" surgical services, and groups of physician experts to identify the specific components of individual global services.

---

[33] Milt Freudenheim, "Which Treatment is More Valuable? New Fee System to Rank Specialties," *New York Times*, April 21, 1988.

There are two other important concerns that the Commission must consider before a fee schedule can be implemented: A conversion factor to transform the RVS into a fee scale in dollars and a method for updating it and geographic multipliers. A conversion factor will likely be developed with budgetary concerns in mind. It could be budget neutral; that is, for the same level of expenditures as are currently spent under the present system. It could also be formulated to increase or (more likely) decrease expenditures. However, it is important to keep in mind that a relative value scale is not intended to reduce expenditures; rather, it is a way of revaluing physician services relative to one another.

PPRC is considering various approaches to updating the fee schedule, including recommendations to Congress and DHHS by an independent panel, the existing regulatory rulemaking process, or the use of a formula linking the conversion factor to an index to yield a predetermined increase in Medicare expenditures.

PPRC will spend 1988 studying and evaluating RVS methods; by March 1989, they hope to present Congress with a blueprint for physician payment reform. Congress will likely decide whether to put a new payment system in place by the early 1990's. In the interim, PPRC recommends that Congress move toward a more equitable system of paying for primary care services (such as office visits, nursing home visits, emergency room, and home visits) by putting a floor equal to a fixed percentage of the national mean under them. The Commission believes this would increase beneficiaries' access to primary care services in those areas where primary care physicians are underpaid.

HCFA warns that the Harvard RVS should not be considered the "magic bullet" capable of solving the Medicare physician payment conundrum.[34] While the RVS will likely correct some of the inequities in the current reimbursement system, it does not address the issue of volume and intensity. There is some concern that a RVS could exacerbate that problem if physicians respond to reduced fees by increasing volume and intensity.

(B) PHYSICIAN DRG'S

Physician DRG's would give physicians, as hopsital DRG's have given hospitals, the incentive to practice more efficiently (within the scope of the payment unit) as the physician would be at risk of costs in excess of the DRG. It is expected that a physician DRG payment scheme for inpatient services would involve the establishment of a predetermined rate for each of the 471 DRG's used under the PPS system. The major advantage of this approach is that it would establish a specified payment amount for all services provided during an inpatient stay. There are, however, numerous questions about the practicality of such an approach for physicians' services. For example, while there are only 475 DRG's for hospitals, there are presently 7,000 different procedures and services recognized by the current system. Further, there are about 500,000 physicians in the United States, compared to only 7,000 hospitals. The

[34] William L. Roper, M.D., Administrator, Health Care Financing Administration, statement before the Subcommittee on Health, House Ways and Means Committee, House of Representatives, May 24, 1988.

sheer volume of physicians' services would also make such an approach problematic. In fiscal year 1989, HCFA expects to process 350 million bills for physicians' services, compared to 11 million inpatient hospital bills.

There is also concern about the appropriateness of a DRG scheme for physicians. The existing DRG system is based on resource use in hospitals; it may not be an accurate measure of physicians' input costs. Another issue is who is going to receive the payment—the hospital, the attending physician or the medical staff? One consideration in making this determination is the degree of financial risk imposed on the various parties involved. For example, an individual physician's caseload may consist of a higher proportion of sicker patients requiring more intensive care than the average for a particular DRG. Placing an individual physician at risk could potentially encourage the provision of less care than was medically appropriate or the avoidance of more severe cases.

Another issue is the potentially dangerous alignment between hospitals and physicians under a DRG payment scheme. Under the existing system, the physician is the last remaining check on quality. If he or she is given the same incentives as the hospital to reduce care, then quality may deteriorate. Other issues involve potential gaming—multiple admissions to maximize reimbursement, shifting care to the outpatient setting, and similar manipulations of the system.

Under the Social Security Act Amendments of 1983, DHHS was required to report to Congress by July 1985 on the feasibility of paying for physicians' services provided to hospital inpatients on the basis of DRG's. DHHS has not yet given Congress the report.

(C) CAPITATION

Capitation is the favored approach of the Reagan administration. Already in place in the form of Medicare health maintenance organizations (HMO's) and competitive medical plans (CMP's), the administration supports their expansion to a regional, or geographic, basis. Geographic capitation would require Medicare to contract with an entity such as a carrier, which would serve as an at-risk insurer in a defined geographical area. Medicare would essentially purchase a specified package of services for a specified per person price. The entity would be responsible for determining payment amounts and payment units. To assure beneficiary access to care at predictable levels of out-of-pocket costs, an entity could be required to obtain physician participation agreements from a certain percentage of physicians in the geographic area.

The Federal Government would be required to determine the per capita (per person) payment amount. Further, certain financial incentives might be in place (such as reduced cost-sharing) to encourage beneficiary participation. The system could be designed to be mandatory for all beneficiaries or optional. Those supportive of this approach believe that placing decisions about fee levels, utilization review, and the selection of providers in the hands of local plan administrators and physicians permits them to be more responsive to varying needs of their populations.

The Reagan administration, while it sees capitation as a long-term solution, has several short-term approaches that they believe would help to control Part B costs under the present fee-for-service system. These approaches include limiting payment fees on certain overpriced procedures, and intensive claims review to validate medical necessity and appropriateness of the level of care. Finally, the administration would encourage Medicare beneficiaries to use preferred provider networks. Providers participating in the networks would be those identified by HCFA as providing high quality care at affordable prices. Intensive utilization review and financial incentives would be used to encourage more appropriate volume and level of intensity of services by those providers participating in the networks.

There are many questions about the effects of these proposals, and they are likely to be heavily scrutinized by Congress and organizations .representing the elderly. Initial concerns regarding the preferred provider networks and the capitation plan include whether beneficiaries will have the information and knowledge to make rational selections among the various plans. There is also a question of skimming and adverse risk. For example, the healthier beneficiaries may opt for the capitated scheme leaving the basic Medicare Program to absorb the higher cost, less healthy patients. Finally, there is concern that the administration will be driven by budget concerns to hold the capitation payments low and to pare down the required benefit package.

(D) MODIFYING THE CURRENT SYSTEM

On April 12, 1988, HCFA announced in the *Federal Register* its interest in reordering the existing CPR system by eliminating specialty differentials. HCFA is "considering publishing a proposed rule that would eliminate specialty differentials in Medicare prevailing charges for all physician services except, possibly, for medical visits and consultations." [35] Under their plan, the amount of overall Medicare payments to physicians would not change; rather, they would be redistributed by channeling more Medicare payments to general practitioners, family practice physicians, and internists, with less money going to surgeons and other specialists.

HCFA cites the lack of a commonly accepted definition of "specialist" as a major reason behind its desire to eliminate the differentials. Some carriers now grant differentials only when the physician is board-certified and has specific training. Others set a single prevailing charge for all physician services without regard to specialties. However, HCFA is "also considering adding a definition of 'specialist' to the regulations, to the extent we continue to recognize different specialty differentials." [36] HCFA has asked for public comment on its proposal by June 13, 1988.

IX. CONCLUSION

Medicare expenditures on physician services—along with beneficiary out-of-pocket liability—will undoubtedly continue to grow

---

[35] *Federal Register*, vol. 53, No. 70, April 12, 1988, Proposed Rules, p. 12040.
[36] *Federal Register*, p. 12040.

even if measures are taken to control costs. Increases in health care expenditures across the board in the United States demonstrate that while the increase in physician expenditures under Medicare is possibly more dramatic than increases found elsewhere in the health care market, it is not an isolated occurrence.

Although pressures to limit expenditures will undoubtedly mount, it is important that Congress and other health policymakers carefully consider the various reform options and their possible outcomes. Of all the options, a fee schedule would appear to have the most momentum behind it. However, it is not without its flaws. It could have potentially harmful effects on beneficiary out-of-pocket liability unless safeguards are put in place. For example, a Medicare patient undergoing a lens implant currently must pay $289 coinsurance (20 percent of the average bill of $1,444) if the ophthalmologist accepts assignment; more if not. Under a fee schedule, the average bill for this procedure would be about $529,[37] reducing the 20 percent copayment to $106. However, the nonassigned liability could be enormous ($915=$1,444−$529) if the physician does not accept assignment. Most aging advocacy groups endorse mandatory assignment—and physicians are generally opposed as they believe they should be able to determine how much they can charge each particular patient.

Congress faces a difficult task in formulating a new physician reimbursement system that ensures beneficiaries' access to care while limiting their out-of-pocket expenses and that protects physician income and autonomy from great decline while lowering the Federal deficit. All of these considerations are equally powerful, and it remains to be seen which will hold sway in the final consideration of this issue.

BIBLIOGRAPHY

American Medical Association. *Medicare Physician Reimbursement: An AMA Perspective.* Chicago: The American Medical Association, April, 1987.

Anderson, Gerard F., and Jane E. Erickson. "National Medical Care Spending." *Health Affairs,* Vol. 6, No. 3, Fall, 1987, pp. 89-104.

Bureau of Labor Statistics. Data from the establishment survey, *Employment and Earnings.* Washington, D.C.: GPO, various issues in 1986 and 1987. As cited in "National Health Expenditures, 1986-2000."

Burney, Ira and George Schieber. "Medicare Physicians' Services: The Composition of Spending and Assignment Rates." *Health Care Financing Review,* Vol. 7, No. 1, pp. 81-96.

Etheredge, Lynn and David Juba. "Medicare Payment for Physicians' Services." *Health Affairs,* Vol. 3, No. 4, Winter, 1984, pp. 132-137.

Freudenheim, Milt. "Which Treatment is More Valuable? New Fee System to Rank Specialties." *New York Times,* April 21, 1988.

Fisher, Charles, R. "Impact of the Prospective Payment System on Physician Charges Under Medicare." *Health Care Financing Review,* Vol. 8, No. 4, Summer, 1987, pp. 101-105.

Garfinkel, Steven A., Arthur Bonito, and Kenneth R. McLeroy. "Socioeconomic Factors and Medicare Supplemental Health Insurance." *Health Care Financing Review,* Vol. 9, No. 1, Fall 1987, pp. 21-30.

Harvard Medicare Project. *Medicare: Coming of Age. A Proposal for Reform.* Boston: Harvard College, John F. Kennedy School of Government, 1986.

Health Care Financing Administration. "Medicare Program; Discontinuation of Prevailing Charge Differentials for Specialists." Request for comments printed in the *Federal Register,* Vol. 53, No. 70, April 12, 1988, pp. 12037-12041.

[37] Janet B. Mitchell, William B. Stason, Kathleen A. Calore, Marc P. Freiman, and Helene T. Hewes, "Are Some Surgical Procedures Overpaid?", *Health Affairs,* Summer, 1987, p. 130.

Health Care Financing Administration, Office of the Actuary, Division of Cost Estimates. "National Health Expenditures, 1986-2000." *Health Care Financing Review,* Vol. 8, No. 8, Summer, 1987, pp. 1-36.

Health Care Financing Administration, Bureau of Quality Control. *Carrier Reasonable Charge and Denial Activity Report.* Washington, D.C.: GPO, 1985.

Holahan, John and Lynn Etheredge, eds. *Medicare Physician Payment Reform: Issues and Options.* Washington, D.C.: The Urban Institute, 1986.

Hsaio, William and William Stason. "Toward Developing a Relative Value Scale for Medical and Surgical Services." *Health Care Financing Review,* Vol. 1, No. 2, Fall, 1979, pp. 23-38.

Lubitz, James and Ronald Prihoda. "The Use and Costs of Medicare Services in the Last Two Years of Life." *Health Care Financing Review,* Vol. 5, No. 3, Spring, 1984, pp. 117-132.

McMillan, Alma, James Lubitz, and Michael Newton. "Trends in Physician Assignment Rates for Medicare Services." *Health Care Financing Review,* Vol. 7, No. 2, Winter, 1985, pp. 59-75.

Mitchell, Janet B., William Stason, Kathleen A. Calore, Marc P. Freiman, and Helene T. Hewes. "Are Some Surgical Procedures Overpaid?" *Health Affairs,* Vol. 6, No. 2, Summer, 1987, pp. 121-131.

National Center for Health Statistics. R.J. Havlik, B.M. Liu, M.G. Kovar, et. al. "Health Statistics for Older Persons, United States." *Vital and Health Statistics,* Series 3, No. 25. Washington, D.C.: GPO, 1987.

O'Sullivan, Jennifer. *Medicare: Physician Payments.* Washington, D.C.: The Library of Congress, Congressional Research Service, February 1988.

Owens, A. "How Much of Your Money Comes From Third Parties." *Medical Economics,* April 4, 1983, pp. 264-273.

Physician Payment Review Commission. *Annual Report to Congress.* Washington, D.C.: GPO, March 1988.

Physician Payment Review Commission. *Medicare Physician Payment: An Agenda For Reform. Annual Report to Congress.* Washington, D.C.: GPO, March 1987.

Prospective Payment Assessment Commission. *Medicare Prospective Payment and the American Health Care System. Report to Congress.* Washington, D.C.: GPO, February 1987.

Prospective Payment Assessment Commission. *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services.* Washington, D.C.: GPO, April 1987.

Reuter, James, Anne Stewart, and Janet Kline. *Medicare Part B: The Supplemental Medical Insurance Program.* Washington, D.C.: The Library of Congress, Congressional Reseach Service, February, 1986.

Reynolds, R. and Abram, J., eds. *Socioeconomic Characteristics of Medical Practice, 1984.* Chicago: The American Medical Association, 1984.

Roper, William L., Administrator, Health Care Financing Administration. Statement before the Subcommittee on Health, House Ways and Means Committee, U.S. House of Representatives, May 24, 1988.

U.S. Congress, Congressional Budget Office. *Physician Reimbursement Under Medicare: Options for Change.* Washington, D.C.: GPO, April 1986.

U.S. Congress, General Accounting Office. *Reimbursing Physicians Under Medicare on the Basis of Their Specialty.* Washington, D.C.: GPO GAO/HRD 84-94, September 1984.

U.S. Congress, Office of Technology Assessment. *Payment for Physician Services: Strategies for Medicare.* Washington, D.C.: GPO, February 1986.

U.S. Senate, Special Committee on Aging. *The Health Status and Health Care Needs of Older Americans.* Washington, D.C.: GPO, 1986.

The Villers Foundation. *On the Other Side of Easy Street.* Washington, D.C.: The Villers Foundation, 1987.

Wilensky, Gail R., and Louis F. Rossiter. "The Relative Importance of Physician-Induced Demand in the Demand for Medical Care." *Milbank Memorial Fund Quarterly,* Spring, 1983, pp. 252-277.

APPENDIX

Item 1

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

April 20, 1988

John S. Zapp. D.D.S.
Director, Washington Office
The American Medical Association
1101 Vermont Avenue, N.W.
Washington, D.C. 20005

Dear Dr. Zapp:

As a follow-up to the Senate Special Committee on Aging's November 2 hearing on the Medicare Part B premium increase, my staff is presently in the process of preparing a Committee report on physician payment issues. The purpose of this report is to furnish a source of background information, an analysis of recent legislation, and a discussion of possible payment reform options in the context of limiting Medicare beneficiaries' out-of-pocket costs and assuring adequate and fair reimbursement for physicians' services. The report will also provide a forum for various interested organizations to express their views on this subject.

I would like to take this opportunity to invite the American Medical Association to submit a statement for inclusion in our publication. The Committee is interested in hearing not only about the issues as you see them today, but also your predictions and recommendations for the future. We encourage you to include in your statement your organization's response to two recent events that will likely have a major impact on congressional consideration of this issue: the release of the Physician Payment Review Commission's second annual report to Congress, and the Health Care Financing Administration's interest in reordering the existing physician payment system as noted in the April 12 Federal Register.

We ask that your statement be single-spaced, and no longer than 10 pages in length. If you would like to participate, please send your statement to the following address by June 1:

Special Committee on Aging
U.S. Senate
Dirksen G-41
Washington, D.C. 20510-6400

Attention: Ms. Holly Bode

I believe this Committee print will provide invaluable information in the effort to control beneficiary cost-sharing and in restructuring the Medicare physician reimbursement system. As these issues will undoubtedly receive serious consideration later this year and particularly in the 101st Congress, it is my intention to distribute this print to all Members of Congress and pertinent committees. If you have any questions regarding this, please contact Ms. Holly Bode of my Aging Committee staff at 224-5364. I look forward to hearing from you.

Best regards.

Sincerely,

John Melcher

Chairman

Item 2

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

concerning

Medicare Part B

for

SENATE SPECIAL COMMITTEE ON AGING

June 9, 1988

Beneficiaries have much at stake in any reform of the physician payment system under medicare. The impact on beneficiary out-of-pocket expenses of any change in payment is just one of many crucial issues that must be carefully studied. We must learn which beneficiary groups use which physician services and the distribution of the resulting costs. The Association looks forward to working with Congress to create a system that meets beneficiary needs for cost-effective, quality health care.

Beneficiary Liability for Physician Services

Even if we look only at physician charges for covered services, beneficiaries are directly liable for 60% of physician charges. This patient liability includes the Part B premium, annual deductible, co-payments for approved charges, and excess billing for unassigned claims. (A more complete description is included in the attached fact sheet.)

Nearly all beneficiaries pay the Part B premium and that premium has been rising steadily -- up 150% since 1977. The annual premium rose by 15% between 1986 and 1987. The premium then increased another 38.5% in 1988 -- in contrast a Social Security cost-of-living-adjustment (COLA) of only 4.2%.

In addition to the premium, beneficiaries have other liabilities under Part B. Most older persons actually pay about

$100 in out-of-pocket costs before covering the $75 deductible because only Medicare's allowed charges count toward the deductible. Beneficiary liability for the 20% Part B co-insurance more than doubled between 1980 and 1984 and rose from 20% of overall Medicare liability to 32% between 1975 and 1985. Despite increased acceptance of assignment, charges associated with non-assigned claims totaled $2.6 billion in 1985 - an increase of 100% since 1980. In addition there is enormous variation in assignment rates by state and physician specialty - factors over which patients have no control.

Health Care Costs

Skyrocketing costs afflict all aspects of fee-for service medicine. Even without changes in the terms of coverage, beneficiaries pay more each year. Unprecedented increases in program costs are not limited to Medicare; federal employees' health insurance premiums have also gone up about 30% this year. HMO's with medicare risk contracts whose increases are based on fee-for-service sector are expected to rise much more slowly next year.

The cause of this latest crisis in Medicare cannot be attributed to beneficiary behavior. Government statistics show that the average annual number of physician office visits per enrollee has been virtually the same for the past decade. This figure is approximately 5 office visits per enrollee. What has changed is the price and intensity of services provided during these visits. These two factors - the intensity and price of services - jointly account for most of the historic increases in Part B outlays. Beneficiaries do not control either of these factors.

In addition, our current health care system fails to control utilization effectively. Physicians in the fee-for-service sector implicitly have a blank check. The physician determines the clinical management of the patient's case - what tests and procedures are to be done. Unbundling of services - charging for each step in a service rather than the whole package -- has also contributed to the increase in volume and therefore program costs, but no one knows by how much. Again, the beneficiary has little or no control over those decisions. Beneficiaries and Congress need to ask what value we are receiving for our money.

Physician Payment Reform

Congress identified the need for physician payment reform under Medicare when it created the Physician Payment Review Commission to create a blueprint for reform. This current crisis makes that reform all the more necessary and urgent.

The Association firmly believes that Part B of Medicare must be reformed as quickly as possible to achieve the following long-term goals:

1. **Protect beneficiaries from large and unpredictable out-of pocket costs;**
2. **Control program outlays so increases are more in line with general inflation;**
3. **Reform physician payment so that fees are based on a resource based relative value scale with increased payments for undervalued services such as nursing home visits and primary care of those with multiple chronic conditions;**
4. **Deliver medically necessary and appropriate care by developing utilization controls based on quality of patient outcomes.**

Our recommendations for payment reform are based on several important principles. First, reduced Medicare payments for physician services, such as those adopted under the rubric of "inherent reasonableness", should not result in cost-shifting to beneficiaries. Unless these reductions are accompanied by statutory limits on balance billing, this inevitably will occur. We favor the approach to limits on payments like those Congress adopted for cataract surgery in the FY 1987 Budget Reconciliation Act. Beneficiaries already directly pay nearly $3 billion for physician fees in excess of Medicare's allowed amount. Beneficiary liability will surely skyrocket if Congress and the Physician Payment Review Commission pursue program savings without including protections from balance billing on unassigned claims.

Second, revision of Medicare's physician payment system should not just satisfy physician perceptions of fairness and rationality. A truly meaningful payment reform must also limit beneficiary liability to predictable and manageable amounts. In our view, there is no reason why physicians ought not to accept Medicare's allowed fee as payment in full if that amount is based

on a system that is objectively fair and reasonable. That is, mandatory assignment should be a component of a reformed Part B payment method.

The Association approaches the issue of mandatory assignment absent fee reform with caution because of the risk of creating access problems for beneficiaries residing in areas with low assignment rates and low physician/population ratios.

Third, efforts to control Part B expenditures must be designed to ensure that Medicare payments are not set so low that access to care is jeopardized.

Fourth, since a large component of increased outlays for physician services is an increased number and intensity of services per physician contact, utilization review must accompany cost control lest physicians off-set lower fees by higher volume of services. There is little evidence that increased intensity of physician services has appreciably improved the health status of beneficiaries.

Organized medicine for many years has stated that it can police itself. We suggest that beneficiaries, physicians and Congress cooperate to address noted above - protection from an increasing beneficiary liability, fair fees, and reduced program costs. Moreover organized medicine must begin to play a more cooperative role in developing utilization controls for the delivery of services which will increase the quality of care as well as holding the line on program costs.

Administrative Issues

In addition to creating a rational payment system reform also needs to foster between physician/patient interaction. This requires a Medicare program that is predictable, understandable, accessible, and accountable.

Beneficiary satisfaction with Medicare has two dimensions. First, if beneficiaries believe that Medicare provides access to medical services that are both necessary and of high quality, beneficiaries will be basically satisfied with the program. However, few consumers have the knowledge to understand the clinical management of their medical care. Beneficiaries know subjectively if they feel better or not following treatment. But patients have to trust their physician in the types of tests ordered and the treatment prescribed. While consumer groups like AARP urge beneficiaries to become informed consumers, this

knowledge is usually limited to price, insurance coverage, and reputation of the physician or facility. Only when professionals themselves agree on standards of care will beneficiaries be able to participate more fully. Under the current system of payment, it is difficult for consumers to predict out-of-pocket costs for services prior to the delivery of services and hence they cannot act as prudent purchasers.

The second area of beneficiary satisfaction with the Medicare program however is more measurable. That is the ease with which the beneficiary can interact with the administration of the program. Beneficiaries and physicians alike complain about the current administration of Medicare. Questions cannot be answered accurately or on a timely basis; the paperwork is cumbersome and confusing. AARP surveys of beneficiaries reveal extensive problems in filing claims, for example respondents report that their claims are frequently lost or returned for additional information.

Most importantly, payments for covered services are unpredictable and coverage varies greatly from region to region. For example, AARP has had reports that in some areas carriers will not permit payments for general anesthesia for pacemaker insertions. It has been reported to us that in one area a carrier would not pay for a third check up in one year on a patient's unstable glaucoma. Yet these services could be paid by Medicare in another region by another carrier. From the beneficiary point of view it makes little sense to have a national insurance program in which payment screens developed by the local carrier can block access to needed care and are not based on quality of care outcome studies. Controls on both volume of services and cost of services are necessary in the Medicare program. However, local utilization screens result in unnecessary variations in coverage and payment levels. In addition, beneficiaries and their doctors all too frequently learn of these payment screens after services have been provided. Beneficiaries want to know the rules of the game beforehand whenever possible to avoid.

These problems in filing claims and receiving proper payment are frustrating for physicians and beneficiaries alike. Poor program administration discourages physicians from participating

in the Medicare program and creates a paperwork burden for beneficiaries. Such incidents do not provide the peace of mind that insurance is supposed to provide. Predictability is key to both physician and beneficiary satisfaction with the program.

The Canadian Experience

AARP's goals of preserving patient access to the full range of medically necessary care at a cost that is fair to physicians, individuals, and taxpayers in general are certainly achievable if we have the political will. For example, Canada has provided all its residents with comprehensive hospital and medical insurance for more than twenty years at a cost that is significantly below ours in terms of total per capita health expenditures and per cent of G.N.P. They have done so while preserving complete freedom of choice ot choose physicians who are paid on a fee for service basis.

Since Canada's federally mandated health system is administered by its provinces, a great variety of means -- reflecting local culture and preferences -- are used to control cost, preserve access, enhance and administer benefits, and negotiate with organized groups of physicians about individual fees and total expenditures. The advantages of Canada's system to consumers include total absence of confusing and time-consuming paperwork, complete relief from out-of-pocket expenditures for covered services, and the satisfaction of knowing that everyone is entitled to the same basic benefits. Because there is only one payer, administrative costs are reduced, the system is relatively simple and the government can effectively hold down costs without interfering in clinical decisions.

Conclusion

Before embarking on payment reform, the Association urges Congress to consider the impact on beneficiaries and create a system which meets the needs of those who use the Medicare program.

Item 3

AGE AND YOUTH IN ACTION

GRAY PANTHERS

PROTECT AND

June 1, 1988

Senator John Melcher
Chairman
Special Committee on Aging
U.S. Senate
Dirksen G-41
Washington, D.C. 20510-6400

Attention: Ms. Holly Bode

Dear Chairman Melcher:

Gray Panthers submits the attached statement, in response to your letter of April 26, 1988 inviting Gray Panthers to state the views of our organization on physician payment issues relative to services rendered Medicare Beneficiaries, with particular reference to the second annual report to Congress of the Physician Payment Review Commission, and the proposals of the Health Care Financing Administration affecting the existing physician payment system, as noted in the April 12 Federal Register.

Gray Panthers will appreciate your Committee's consideration of the views expressed herein.

Respectfully,

Frances Humphreys

Frances Humphreys
Director
Washington D.C. Branch of the
Gray Panthers National Office
1424 16th Street, N.W., L-1
Washington, D.C. 20036
(202) 387-3111

Attachment

STATEMENT

The Physician Payment Review Commission was created by Congress in 1985, "to advise the Congress on reforms of the methods used to pay physicians for services to Medicare Beneficiaries." The Commission issued its first report in March 1987, establishing "goals for physician payment policy"; and it "charted a direction for Medicare program reform, calling for the development of a fee schedule for Medicare."

In his Preface to the Commission's Annual Report to Congress March 31, 1988, Chairman Philip R. Lee, M.D., stated that the Commission has "moved well into developing a fee schedule proposal. It has also broadened its focus to encompass analysis of options to moderate the growth in expenditures without reducing quality of care and issues related to capitation and Medicare date needs."

The Executive Summary of this late report, referring to the question of "mandatory assignment", expresses the Commission's concern about "beneficial financial liability." The Commission also recognizes the importance to physicians of Medicare's longstanding policy to give physicians the choice whether to accept assignment." "The Commission is examining evidence ... and reviewing options ... to improve current approaches and determine what policies would be appropriate to accompany a fee schedule."

Gray Panthers takes little satisfaction from a Commission finding that although almost 3/4 of Medicare claims are on assignment, extra billings on non-assigned claims are reported to have totalled nearly $2.5 billion in 1987.

The Commission also reported that other changes or extensions of Medicare policy presently in place or programmed, such as increasing incentives to doctors to accept assignment, or "participate" for a year's trial, helping beneficiaries find doctors who will forego extra billing, "constraining" extra billing charges, etc., have contributed to increases in overall assignment rates and the percent of total services provided by participating physicians.

Pending further development of the position and recommendations of the Physician Payment Review Commission on the projected Relative Value Scale and the manner and terms of its use and application, Gray Panthers earnestly recommends that the Congress require all physicians wishing to attend Medicare beneficiaries to do so on the basis of assignment.

Gray Panthers recognizes that the Physician Payment Review Commission -- in pursuit of its charge to examine and, where possible to propose improvement in the financial protection afforded Medicare beneficiaries under existing methods of reimbursement for professional services-- strongly and clearly favors greater "participation" and acceptance of the assigned eligible fees for eligible services by physicians. We recognize the efforts cited above, on the part of HCFA, to persuade physicians voluntarily to "participate", and to aid beneficiaries in availing themselves of needed services under the optimal terms to which they are entitled. However, we note that efforts based on incentives to "voluntarily" accept assignment thus far, have failed to receive an overall adequate response from physicians and overbilling continues to contribute significantly to the heavy burden of health care costs for Medicare beneficiaries.

Gray Panthers urges the Physician Payment Review Commission -- in its anticipated further study and refinement of the Relative Value Scale, as the presently preferred device for improving the equity and adequacy of reimbursing physician services for Medicare beneficiaries -- to eliminate extra billings; and to establish clearly the principle and the prospect that services will be rendered on a fully paid basis, avoiding not only the uncertainty of patient obligation, but the frequently onerous burden of "extra billings."

GRAY PANTHERS SUMMARIZES ITS RATIONALE IN SUPPORT OF "MANDATORY ASSIGNMENT" AS FOLLOWS

1. On average, Medicare beneficiaries spend a higher proportion of their incomes on health care today than they did before Medicare became effective in 1965.

2. Mandatory assignment clearly makes health care services more readily and generally available and accessible to all beneficiaries, as and when needed.

3. Required payment by Medicare beneficiaries of substantial and increasing annual deductibles and co-insurance charges (plus increasing deductions from retirement payments under Social Security) -- in aggregate -- represent in all cases substantial outlays, and in many cases, genuine hardships for Medicare patients. It should be noted that beneficiaries suffered an unprecedented 38% premium increase

in Part B premiums in 1988 and must expect more increases in the future in both the basic Part B premium and new supplemental premiums that will result from the soon to be enacted catastrophic health care protection legislation.

4. The assurance of such service without unpredictable, and perhaps unavailable personal financial obligation encourages beneficiaries to seek early care, avoiding possible heavy costs and risks of delayed medical attention.

5. Mutual recognition of the acceptance of assignment by the physician creates an environment favoring the best possible patient/doctor relationship; obviating uncertainty as to costs and obligations for both parties.

6. For the above reasons, acceptance of the assigned fee by the physician makes Medicare more effective as preventive medicine -- to the advantage of both patient and society.

7. Gray Panthers respectfully observes that four New England states - Connecticut, Massachusetts, Rhode Island and Vermont have made assignment mandatory by law (some of the statutes applying only to individuals or couples with low or moderate incomes). Such bills are pending in California, New Jersey, New York and Ohio, but have been rejected in others. It would clearly be desirable to reach and effect a national policy on this issue.

8. The evolution and eventual implementation of a national Relative Value Scale for all definable medical and health services and procedures, operating through established unit valuations (expressed in monetary fee schedules determined by local action) appears to offer a practical and acceptable approach to a program of medical service reimbursement for Medicare beneficiaries.

With respect to the proposals of the Health Care Financing Administration (HFCA), affecting the existing Physician payment system, as noted in the Federal Register, April 12, 1988, Gray Panthers offers the following comment: The issue in question is a proposal to discontinue the establishment of "separate prevailing charge screens for physicians' services based on specialty practice, with the possible exception of specified medical visits and consultations."

The main point of inquiry is the question whether identical or similarly coded services, when rendered by a physician recognized as a specialist in that area of practice, should be reimbursed at a higher or different level than a physician equally competent to render such service, though not recognized as specializing in that area of practice.

Gray Panthers is concerned that while there may be legitimate reasons for establishing different prevailing charge rates based on whether the physician is deemed a specialist in performing the service or procedure, those rates will have a financial impact on the reasonable charge rates that Medicare is using currently in calculating physician reimbursements. If prevailing charges are reduced, especially as the prevailing charge is in most instances to date the reasonable charge, beneficiaries will have to incur greater out-of-pocket costs.

It is also generally recognized that physicians engaged in general primary care are more likely than "limited specialists" voluntarily to charge lower fees for the same or equivalent services.

Absent technical data and expertise in the issues under review, Gray Panthers questions the timeliness of the issues here raised, in the light of the current ongoing efforts of the Senate Special Committee on Aging, with the advice and counsel of the Physician Payment Review Commission, created and empowered by Congress in 1985, "to formulate and provide the basis for Congressional action intended to effect desirable changes in the methods used to pay physicians for services to Medicare beneficiaries" - action by HCFA now would be premature.

Gray Panthers wishes to express its appreciation of the opportunity your Committee has afforded it to present these views.

Item 4

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

2000 K Street, N.W., Suite 800, Washington, D.C. 20006 (202) 822-9459

June 1, 1988

The Honorable John Melcher
Chairman
Special Committee on Aging
United States Senate
G-41 Dirksen Senate Office Building
Washington, D.C. 20510-6400

Dear Chairman Melcher:

It is with great pleasure that we accept the invitation to express the National Committee's views regarding Medicare Part B premium increases and physician payment reform to be included in your forthcoming document on these important subjects. Enclosed please find our statement.

We would also like to take this opportunity to commend you on your leadership in initiating this publication to be used as background information for the increasingly intensive debate on physician payment reform. As is expressed in our statement, the National Committee feels strongly that we cannot accept any type of payment reform without assuring cost containment for beneficiaries. We cannot continue to pass-through the spiralling cost of health care to seniors.

Again, thank you for providing the opportunity for the National Committee to submit a statement. Should you have any questions regarding this submission, please feel free to contact me or our Director of Policy and Research, William J. Lessard, Jr.

Sincerely yours,

Landis Neal

Landis Neal
Executive Director

The National Committee to Preserve Social Security and Medicare appreciates the opportunity to express the views of the National Committee regarding Medicare Part B premium increases and physician payment reform. The National Committee has more than five million members and supporters, the majority of whom are Medicare beneficiaries. As a consequence, they are deeply concerned about rising health care costs. Our members remind us daily about the failure to contain health care costs and the struggle they face to make ends meet. The pain resulting from this January's 38.5 percent Part B premium increase has not yet subsided.

In a recent survey of National Committee members, an overwhelming 72 percent of respondents agreed the federal government should regulate doctors' and hospital fees. Two-thirds of the membership ranked, as one of their top two priorities, that doctors be required to accept assignment. Controlling premium increases was also a high priority.

In response to the 38.5 percent premium increase, Congress promised last year to reform physician payments. But another year has almost passed. Physician payment reform is still somewhere down the road and Congress has yet to protect seniors from out-of-pocket medical care costs. There was little effort to stop the $6.90 monthly Medicare premium increase effective last January, and extended for another year is beneficiaries' 25 percent share of program costs. Without this deliberate legislative action, the law would have reverted back to capping premium increases to the cost-of-living adjustment (COLA) beginning in 1989.

Congress complains about the costs of Medicare Part B and doctors complain about unfair Medicare payments. But tying premium increases to program costs and voluntary assignment permits Congress to pass the costs of the current Medicare payment system on to beneficiaries and doctors to pass on higher fees to some extent. This reduces the incentive of Congress and doctors to be committed to physician payment reform.

The National Committee strongly endorses physician payment reform, but physician payment reform alone should not be relied on to protect beneficiaries from out- of-pocket costs. Therefore, the National Committee also recommends capping premium increases to the Social Security COLA and making assignment mandatory.

Physician Payment Reform

The Physician Payment Review Commission has recommended that Medicare adopt a relative value scale. While not the only possible payment reform, a relative value scale has potential to reduce overall program costs and make the payment system fairer.

After the recent experience of quality care problems with Medicare's hospital cost containment program, beneficiaries worry about the impact of physician payment reform on quality. Capitation and DRG's as physician payment reform alternatives have more potential for quality care problems than a relative value scale. A relative value scale may even improve quality by increasing payments to primary care physicians who generally have the most extensive and direct contact with their patients, but who have the lowest income among Medicare doctors. Average annual income for general family practioners was $80,300 in 1986 compared to the overall average of $119,500.

Medicare Premium Increases

Medicare Part B program costs have steadily increased at the average rate of 18 percent a year over the last decade and indications are that this trend is continuing. Unless Congress acts to protect beneficiaries they will again be subject to a substantial premium increase next January. The Health Care Financing Administration estimates the premium will increase from $24.80 to $28.00 next January. This would be a 12.9% increase and is 60 percent higher than the $2.00 increase that Congress considered reasonable at the end of last year. When the final increase is determined, the premium increase will probably be even higher. The Conference Report of last year's Omnibus Budget Reconciliation Act committed Congress to review the HCFA premium increase if it was higher than $2.00 a month.

Our members are deeply concerned about the ever-increasing premiums. One National Committee member, Virginia Robert from Mira Loma, California, writes, "Something must be done soon to improve Medicare coverage and to stop the increases in premiums. We seniors cannot absorb any more increases. Our rent goes up, our insurance goes up, our food goes up and any Social Security increase is eaten up many times over. Most of us barely exist." Another member, Dale Priest from Austin, Texas, states, "They are taking out so much now from our Social Security that any more reductions will cause considerable hardship for people like us with very limited income outside of Social Security." Ruth Fisher of Charlotte, North Carolina, laments, "I am wondering if you ever realize how hard it is to live on less than $4,000 a year. . . We cannot afford another raise in Medicare."

Mandatory Assignment

After three years, the Participating Physician Program has failed to convince 70 percent of doctors to accept the Medicare-approved charge as full payment for all patients and there is little reason to expect the percentage to increase significantly. While the overall assignment rate has increased, there are significant variations in assignment rates by geographic location, by specialty, by type of service and setting of service. This means that some seniors have better access to physicians who will accept assignment than do others. And even when a beneficiary chooses a primary care physician who accepts assignment, the senior frequently has little control over the specialists to whom he or she is referred.

By increasing fees for primary care physicians, relative value scale may increase the participation rates of general and family practitioners who have only a 25.6 percent and 27.1 percent rate of participation currently. But the weakness of the voluntary program is that the relatively high participation rates for radiologists, pathologists and surgeons (39.5, 37.7, 37.2) are likely to decline if the relative value scale reduces their fees as it is likely to do.

The Physician Payment Review Commission reports that in 1987 doctors charged beneficiaries between $2.5 and $3.1 billion in additional charges or about $82 to $100 per beneficiary. Beneficiaries who patronize nonparticipating doctors who will not accept assignment must pay an average of 40 to 50 percent of the bill compared to the 20 percent paid by beneficiaries who use participating doctors. Seniors are already paying an average of over $2,100 annually (including premiums) in out-of-pocket health care expenses and many can ill afford to pay the additional doctor charges.

The expense of balance billing can keep seniors from seeking medical attention when it is warranted. We frequently hear from seniors who cancel doctors' appointments because they cannot afford what it costs. As stated in the Physician Payment Review Commission report, if physicians who accept assignment are readily available, beneficiaries are less likely to avoid or postpone care for fear of large, unpredictable out-of-pocket costs. Balance billing causes hardship for many beneficiaries even if they have private insurance to supplement Medicare, because few medigap insurance plans cover more than the 20 percent copayment.

Another important aspect of doctors accepting assignment in the Medicare program is the simplification of paperwork. Participating doctors bill Medicare directly and follow up with necessary reconsiderations or appeals. These processes tend to be confusing and taxing on seniors. One member from Placerville, California, illustrates well the burden of balance billing, "I lie here at home in a hospital bed, in shock, facing the fact that in all cases where assignment was not taken by a doctor or a lab, Medicare approved less than half, and paid 80 percent of that amount; in some cases they flatly disallowed any payment for what appeared to be legitimate charges. I know I may appeal, but am too ill to do so, since my condition has worsened since I returned home."

More and more beneficiaries are aware of the difference between participating and nonparticipating doctors. However, it is not always easy for seniors to switch to a particpating doctor if they have patronized a doctor who refuses to take assignment. Going to any doctor can be anxiety provoking for seniors; going to a new doctor only increases this anxiety.

Conclusion

Since the inception of the Medicare program and up until very recently, doctors have set their own prices for services. They continue to be free to decide whether they want to accept Medicare assignment and whatever the doctor decides, the beneficiary pays. The status quo will be a disaster for beneficiaries and Medicare.

Item 5

May 12, 1988

The American Academy of Family Physicians

Washington Office
Suite 770
600 Maryland Ave. S.W.
Washington, D.C.
20024
(202) 488-7448

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: BERC-455NI
P.O. Box 26676
Baltimore, Maryland 21207

Dear Dr. Roper:

The Health Care Financing Administration currently is examining the question of whether and how to modify the policy concerning the use of specialty differentials, specifically whether it should discontinue the establishment of separate prevailing charge screens for physicians services based on specialty practice, with the possible exception of specified medical visits and consultations. The American Academy of Family Physicians strongly supports the elimination of specialty differentials for all physician services, including medical visits and consultations.

The Medicare payment system now allows for different approved charges for similar services based on the use of specialty groupings for establishing prevailing charge limits. Medicare carriers in all but seven states employ specialty differentials, typically resulting in dual prevailings within a carrier area.

The result of this policy is that Medicare approved charges for family physicians are based on different prevailing fees than the charges of other specialists in the same geographic areas providing the same services. For the beneficiary, this means a greater out of pocket expenditure when receiving a service from a family physician than from another specialist, even when the charges for the service are identical. A specific example of this inequity was cited in the 1980 decision of the United States District Court for the Southern District of Michigan in Michigan Academy of Family Physicians et.al. v. Blue Cross and Blue Shield of Michigan and Patricia Harris, Secretary of Health and Human Services. The court noted that in Lansing, Michigan the prevailing charge for an initial comprehensive visit for the non-specialist was $25, and $50 for the specialist. Trial Judge Gilmore wrote, "Solely as a result of Mrs. Deidrich's choice of Philip Lange as her treating physicien, she, while paying the same premium as other Medicare recipients, received less coverage for services performed than had she chosen a physician defined as a "specialist."

AAFP Headquarters:
1740 West 92nd
Kansas City, Mo. 64114

In its March 1988 Report to Congress, the Physician Payment Review Commission concluded that "it would be inequitable and illogical to pay one physician more than another for the same service."[1] In the Michigan Academy of Family Physicians case noted above, the court also addressed this issue, stating, "To the extent that 20 C.F.R. 405.504(b) authorizes the screens set up by the defendants, that regulation is invalid." Subsequently the Court of Appeals for the Sixth Circuit upheld that decision, and on June 9, 1986 the Supreme Court ruled that the lower courts have jurisdiction to consider challenges to Part B Medicare regulations.

As noted in your April 12 notice requesting comments on the possibility of discontinuing specialty-specific prevailing charge screens, the substantive issues in the Michigan court case have not been resolved, at least throughout the rest of the country. The American Academy of Family Physicians submits that there is no justification for continuing specialty differentials, while there are numerous and significant reasons this policy should be discontinued.

Among these reasons -- which will be discussed in greater detail below -- are the fact that the policy is inequitable for both Medicare recipients and physicians providing Medicare services and does not appear to promote any discernible or desirable public policy objective. At the same time, perpetuation of specialty differentials clearly will be counter-productive to achieving several widely-supported public policy objectives, including improved access to physician services through increased numbers of "participating" physicians in the Medicare program and the correction of specialty and geographic maldistribution problems by encouraging increased numbers of young men and women to enter the specialty of family practice. Additionally, the use of specialty differentials unnecessarily complicates the administration of the Medicare program. As stated in your April 12, Federal Register notice, "...eliminating specialty distinctions in paying for similar services would result in a major program simplification for Medicare carriers."

In examining this issue, HCFA has requested comments in the following five areas.

1. The impact of eliminating specialty specific prevailing charge screens on the provision, scope and availability of primary care services, particularly in rural areas and in urban underserved areas:
   a. with medical visits and consultations included
   b. excepting medical visits and consultations

The AAFP has contracted with Lewin-ICF to analyze the impact of paying physicians based on a single prevailing fee, and we anticipate providing this analysis to the Health Care Financing Administration prior to the conclusion of the comment period on this notice. This study will address the impact on overall program costs as well as the impact on different specialists.

---

[1] Physician Payment Review Commission, Annual Report to Congress, Washington, D.C. (1988): p.87.

We do know now, however, that the existing system of specialty differentials provides a significant disincentive for physicians to enter a generalist specialty such as family practice. As stated by PPRC, "Specialty differentials now provide inconsistent and in some cases distorted signals to physicians about which services to provide and what specialized training to undertake."[2] Physicians are less apt to choose family practice as their specialty knowing that when they care for a Medicare beneficiary, the program may consider their care of lesser value than the same care provided by another specialist.

Income has been found to have a positive impact on the number of residents in a specialty, and there appears to be a positive relationship between reimbursement level and physician location choice. New physicians are more sensitive to income variation than are established physicians and the long-run impact of income of specialty and location choice is greater than the short-run impact.[3]

The rising cost of medical education and the declining availability of subsidized student loan programs serve to exacerbate the financial disincentive to selecting the specialty of family practice. Bazzoli found that each additional $10,000 increases in non-subsidized Health Education Assistance Loan (HEAL) debt decreases the probability of choosing a primary care specialty by 7.5 percent.[4] During the 1985-1986 academic year, 82 percent of senior medical students had educational debts that averaged $33,499. Nearly 45 percent of 1987 medical school graduates have debt burdens over $30,000 and 20 percent are over $50,000.[5] Just over 20 percent of all medical student indebtedness is HEAL loans, up from 3.8 percent in 1981.[6]

The preliminary conclusions of the Council on Graduate Medical Education are particularly salient on this point.

> The present financing decreases the attractiveness of certain disciplines to students and tends to produce a concentration of physicians in what may be oversupplied specialties. These incentives are the result of (1) differentials by specialty in reimbursements to physicians for services apart from medical education payments, and (2) differentials by specialty in benefits to hospitals for the use of inpatient hospitalization and other hospital services.

---

[2] Ibid No. 1, p.87.

[3] Fruen, M.A., Hadley, J., and Korper, S.P., "Effects of financial incentives on physicians' specialty and location decisions," Health Policy and Education 1(2) (March 1980): 1-19.

[4] Bazzoli, G.J., "Does educational indebtedness affect physician specialty choice," Journal of Health Economics 4 (1985): 1-19.

[5] Association of American Medical Colleges, "Medical student graduation questionnaire: summary report for all schools," (1987), Washington, D.C.

[6] Personal communication with Sarah Bennett Carr, Office of Governmental Relations, Association of American Medical Colleges, Washington, D.C.

Specialty training choices of physicians affect the medical care system as a total entity, with the current system experiencing a shortage of family physicians at a time of physician surplus in the aggregate. Disincentives to enter family practice are widely apparent in the Medicare program, including the specialty differential. To perpetuate the specialty differential for visits, which comprise a large portion of what family physicians do, is to perpetuate a disincentive for physicians to enter this specialty, and to perpetuate problems of access to primary care services by the Medicare population.

From the standpoint of Medicare beneficiaries, who all pay the same premium, continuation of a specialty differential for visits means that when they see a family physician for a visit, Medicare will pay less than if the visit is to another specialist, and the beneficiaries must pay a higher portion out of pocket. Elimination of the specialty differential for all services will eliminate this beneficiary inequity.

The physician whose services are undervalued compared to other physicians is less inclined to accept Medicare assignment, or to become a participating physician, because of financial constraints. Lack of acceptance of assignment can create a financial barrier to health care, particularly in rural and underserved areas where access already is limited by the lack of availability of physicians.

Eliminating the specialty differential will encourage beneficiaries to seek and physicians to provide primary care services, and will signal to physicians that a career choice of family practice is valued on a par with other specialty choices.

2. The specific similarities and differences in the contents of visits and consultations from one type of specialty to another.

The AAFP has long opposed fee differentials on the basis of physician specialty and is particularly concerned by the implications of justifying such differences for visits on the basis of the amount of time and resources utilized to provide health services.

The Federal Register notice cites a study by Mitchell and Cromwell that suggests that because at each level of patient encounter internists had longer visits and performed and ordered more medical procedures than general practitioners, internists therefore have a more complex case mix than general practitioners. Further, the study suggests that higher specialty charges may be largely attributable to additional time physicians in some specialties spend with beneficiaries.

The suggestion that longer visits equate with greater complexity is not validated in this study, or in other studies which describe the difference in use of resources between internists and family physicians. Furthermore, we are not aware of any study and do not believe any study exists which shows that such differences in the use of resources among different specialists results in different outcomes. The literature has

documented for many years that family physicians do use resources differently than internists, for comparable patients. As Greenwald, Paterson et. al. note, "differences are observed in expenditure of time and use of a broad range of diagnostic and therapeutic techniques. These differences remain significant even after several important characteristics of individual physicians, patients and the practice environment have been controlled." [7]

Cherkin et. al. state, "General internists spend the vast majority of their training in settings where relatively uncommon problems are commonly seen and where role models are often specialists. Most family physicians, however, are trained in settings where uncommon problems are seen with much lower frequencies and where role models are more likely to be generalists. As a result, general internists are trained to use diagnostic tests whose yield in general ambulatory practice may be much lower than that experienced during their residency training."[8] differences in practice style in the provision of services -- absent demonstrable differences in results -- do not justify the suggestion that a service provided by one type of physician is a different service when provided by a physician of another specialty and should be reimbursed at a different rate. As Cherkin notes, "while the more resource-intensive practice style of general internists may in fact yield benefits to patients or to society, there is little in the limited literature to support such a belief."

3. <u>The need to use different codes or modifiers and terminology to describe services in ways that make needed specialty distinctions.</u>

By the way in which this question is worded, it is suggested that some mechanism should be developed to "make needed specialty distinctions." The Academy does not believe that there is a need to make distinctions solely on the basis of physician specialty. However, if it can be determined that truly different services are being coded the same, we do not believe it is inappropriate to develop needed codes to describe the different services. For example, it might be reasonable to expand the visit codes to describe in greater detail the particular activity which occurs during the visit.

However, the point of doing this would not be "to make needed specialty distinctions" but to recognize differences in the services provided, regardless of the specialty of the physician providing the services.

---

[7] Greenwald, H.P., Peterson, M.L., Garrison, L.P., Gart, L.G., Moscovice, I.S., Hall, T.L., and Perrin, E.B., "Interspecialty variation in office-based care," Medical Care 22(1) (1984): 14-29.

[8] Cherkin, D.C., Rosenblatt, R.A., Gart, L.G., Schneeweiss, R., and LoGerfo, J., "The use of medical resources by residency trained family physicians and general internists," Medical Care 25(6) (June 1987): 455-469.

Services which are the same should never be coded differently simply to reflect that the services are provided by different types of specialists. The inappropriateness of developing mechanisms to recognize specialty distinctions becomes glaringly clear with one recognizes that -- as HCFA acknowledges in the April 12 Federal Register notice --"...most carriers accept as specialists those physicians who classify themselves as specialists." That is, even if a plausible argument could be made that there is a valid basis for maintaining specialty differentials, the fact that specialty status is self-designated makes such differentials meaningless.

4. Permitting carriers to maintain separate prevailing charge screens for specific specialties or groups of specialties for medical visits and consultations.

As is clear from our previous comments, the American Academy of Family Physicians does not believe it is appropriate or desirable to permit carriers to maintain separate prevailing screens for any specific specialties for medical visits and consultations. Significant negative policy implications result from separate prevailing charge screens for specific specialists, including impediments to beneficiary access to care, geographic and specialty maldistribution, and inequities to both Medicare beneficiaries receiving services and physicians providing care to Medicare beneficiaries. A policy which permits carriers to retain specialty differentials will perpetuate these significant problems.

Furthermore, administrative simplification through elimination of separate prevailing screens would be of particular benefit to carriers. This may be an important consideration as the complexity of their task has increased as a result of Congressional action (ie. MAACs).

5. Appropriate standards for recognizing a physician as a specialist for Medicare payment purposes.

As outlined in the Federal Register notice, no consensus exists for defining a specialist for payment purposes within the Medicare program. Presently carriers have wide discretion in defining specialists, with inconsistent criteria across carrier areas. The policy results in significant inequities for beneficiaries receiving and for physicians providing similar services to Medicare patients.

Elimination of the specialty differential would obviate the need to arbitrarily define specialists for payment purposes, and would provide a policy whereby Medicare pays for a particular service, remaining neutral as to the specialty of the physician providing the service.

In summary, the American Academy of Family Physicians supports the elimination of specialty differentials in Medicare payment for all physician services, including visits and consultations. Differences in reimbursement should be based on differences in the services provided not on differences in the specialties of the physicians providing the services. We urge the Health Care Financing Administration to immediately begin action to formally eliminate specialty differentials through the regulatory process.

Sincerely,

Harry L. Metcalf M.D.

Harry L. Metcalf, M.D.
President, American Academy of Family Physicians

May 12, 1988

William C. Hsiao, Ph.D.
Department of Health Policy and Management
Harvard University School of Public Health
677 Huntington Avenue
Boston, MA 02115

The American Academy of Family Physicians

Washington Office
Suite 770
600 Maryland Ave. S.W.
Washington, D.C. 20024
(202) 488-7448

Dear Dr. Hsiao:

In March 1988, in preparation for the National Consultative Conference on the Medical Relative Value Scale, five discussion papers were released which indicated the preliminary results of the study by the Department of Health Policy and Management, Harvard School of Public Health to develop a resource-based relative value scale. In general, the American Academy of Family Physicians believes these study papers evidence the tremendous amount of forethought and work which went into the development of the resource-based relative value study. We are encouraged by the preliminary results. We look forward to the release of the final results later this summer, and the eventual implementation of a physician reimbursement system based on a resource-based relative value scale.

Nevertheless, in spite of our generally favorable reaction, there are issues addressed in the study papers which are of concern or unclear. Accordingly, the AAFP offers the following comments and questions for consideration by the study investigators in development of the final study product.

Of principal concern to the American Academy of Family Physicians is the question of whether the study is recommending a single RBRVS for each distinct physician service or a series of specialty-specific RBRVSs for a given service. The draft materials also have been reviewed by Lewin-ICF on behalf of the Academy, and this firm has noted the lack of clarity in the papers on this central issue.

The use of specialty differentials in the current Medicare system is now under examination by the Health Care Financing Administration. HCFA is considering whether and how to modify the policy, specifically whether it should discontinue the establishment of separate prevailing charge screens for physicians services based on specialty practice, with the possible exception of specified medical visits and consultations.

The policy implications of specialty differentials are signficant, and negative. The policy is inequitable for both Medicare recipients and for family physicians providing Medicare services. The perverse incentives in the policy perpetuate specialty and geographic maldistribution of physicians by discouraging physicians from entering the specialty of family

AAFP Headquarters:
1740 West 92nd
Kansas City, Mo 6411

practice. Additionally, the application of specialty differentials adds unnecessary administrative complexity to the Medicare program. As stated by the Physician Payment Review Commission, "Specialty differentials now provide inconsistent and in some cases distorted signals to physicians about which services to provide and what specialized training to undertake."[1]

A specialty specific relative value scale would perpetuate the perverse incentives and inequities in the current system, and would defeat the intent of developing a relative ranking of physician services for payment purposes.

The second issue of concern is the use of mean charges to extrapolate relative values from a single service to a closely related family of services. This approach at first glance appears reasonable, particularly as it applies to procedures, and the discussion with respect to coronary artery bypass grafts where one can count the number of arteries involved in a bypass, is pursuasive. However, the Academy has two objections to this approach: first, it would incorporate into the RBRVS the inequities in the current system by the use of charge data, and second, the coding for office visits is inconsistent with this method of extrapolation.

Using charges to estimate relative values within families of services does not provide a reasonable proxy for the determination of differences in relative work. This is particularly troublesome since the discussion paper indicates that Medicare Part B data will be used in the calculations. This appears to be contrary to the very reason for developing an RBRVS, namely that charges are often irrationally set and bear little relationship to physicians' work. The methodology used in this section of the study appears to perpetuate the current disparity in physician fees.

The assumptions that may be valid in extrapolating the relative value of procedures within families do not apply to visits. One might assume that charges for an initial intermediate office visit would fall between charges of an initial limited office visit and an initial comprehensive office visit. However, examination of the 1984 Medicare Directory of Prevailing Charges does not support this assumption. The pattern of prevailing charges for visits varies widely and unsystematically. For example, the variation between the initial and comprehensive visit varies in some areas by $10, in others by $60, and not at all in still others. In addition, the prevailing charges for the same type of visit vary considerably between carrier areas, due to the wide latitude exercised by carriers in establishing specialty fee screens.

Visit codes are imprecise in describing the services provided, with approximately 100 codes describing all visits in comparison with the approximately 7000 procedure codes. Physician charges for visits reflect many factors other than the work associated with the visit, including economics of the area and artificial limitations imposed by the Medicare program, including Maximum Allowable Actual Charges rules. The use of Medicare charges to extrapolate the relative value of services builds into the RBRVS the very inequities it seeks to eliminate.

Discussion paper IV discusses the relative costs of physicians' specialty practice, and is the third area of concern to the Academy. Specifically, our concern is twofold.

First, the premise in the paper is that practice costs should be apportioned to each S/P in proportion to the work input required by that S/P, with the assumption that S/Ps associated with greater levels of physician inputs will generally also require higher levels of practice costs as well. This method will not capture the actual practice costs for specific services which may vary significantly, although the work input may be similar. For example, the relatively high malpractice costs associated with obstetrical services performed by family physicians and obstetricians may not be taken into account compared to a service associated with low malpractice costs which is assigned a similar relative value. In addition the practice setting is not factored into the calculation, which also may affect the reliability of the data.

Second, the study uses data from the 1983 Physician Practice Cost and Income Survey (PPCIS) for the calculation of physician practice costs. The study paper acknowledges the shortcomings of this data set. We would also note that, according to Lewin-ICF, a more recent PPCIS data set is available, and might be more appropriate.

---

[1] Physician Payment Review Commission, Annual Report to Congress, Washington,D.C. (1988): p. 87.

The practice cost data revealed in the draft papers differs markedly from both AMA and Medical Economics data, specifically with respect to primary care specialists' overhead projections as compared with surgical specialists' overhead. Given the deficiencies in the PPCIS, and the discrepancy between the conclusions in the study versus other data sets, we would encourage the investigators to reconsider the data sources used in the computations.

Discussion paper V presents the preliminary results of RBRVS, their strengths and limitations and their potential impacts if the RBRVS are used in payment policy.

We do have concern about the assumption "that cost differential among geographic regions and by types of organizations will be incorporated into the conversion factor." Geographic differentials in the current Medicare payment system are a significant disincentive to the provision of care in some areas of the country. The application of geographic differentials to the RBRVS could perpetuate these same access problems, particularly in rural areas. The Academy suggests that the investigators delete from the final study report those recommendations which relate to implementation of the RBRVS, as such recommendations are beyond the scope of the study, and may prejudice future decisions.

This concern relates also to the discussion of practice costs on page 35 of paper V, noting that the potential conversion factor for practice costs may have to address the issues of efficiency and organization of physician practice. This suggestion, if implemented, could result in payment policy that discourages small practices of one or two physicians, often the type of practice arrangement in which family physicians participate and which may be the only economically viable practice size for a given geographical and/or service area.

In the "Comments on Future Work," the paper further notes that "the current RBRVS does not take into account the experience or competence of physicians. Further research should be conducted to incorporate some measurement of either experience or competence into a payment schedule to reward greater professional competence." Competence is determined through licensing, hospital privileges, peer review and other mechanisms quite apart from the payment system. A payment system should determine how much will be paid for a given service by a provider licensed to provide the service. We would object to the implication that an adjustment for professional competence should be a factor in implementation of the RVRVS.

Finally, with respect to the discussion concerning redistribution of income among specialties, family physicians are encouraged by the preliminary results, albeit crude, showing "that the gross income of family practitioners and internists may increase by 20 or 30 percent." Family physicians have long believed that many primary care services are undervalued relative to those which are procedurally-oriented, and this belief is validated in these preliminary results. We hope that further adjustments to the RBRVS and the inclusion of conversion factors will not dilute this positive result.

On behalf of the American Academy of Family Physicians I want to express our appreciation for the opportunity to have five family physicians involved in the various technical advisory panels appointed to work with you, and for the opportunity to review and comment on the preliminary conclusions of the study. Congratulations to you and your colleagues on the progress you have made toward development of a more rational and equitable physician reimbursement system.

Sincerely,

Harry L. Metcalf, M.D.

Harry L. Metcalf, M.D.
President

Financial Impact Of Reimbursing Physicians Based On A Single Prevailing Charge

By

Lewin/ICF
a division of
Health and Sciences Research Incorporated
1090 Vermont Avenue, N.W.
Suite #700
Washington, D.C. 20005

FINANCIAL IMPACT OF REIMBURSING PHYSICIANS BASED ON A SINGLE PREVAILING CHARGE

The system of reimbursing physician services under Medicare has received a great deal of criticism in recent years, largely fueled by rising Medicare expenditures for these services and the belief that the current reimbursement system creates distortions in payments for physician services. One distortion is believed to result from the use of specialty differentials[1] in establishing prevailing charges.[2] These specialty differentials have been criticized because in some cases physicians providing the same service but in different specialties receive different payments. Specialty differentials may provide unintended incentives to physicians in deciding which services to provide and which specialized training to undertake.

The Health Care Financing Administration (HCFA) currently allows Medicare carriers[3] to establish their own specialty differentials in establishing the prevailing charge. Medicare carriers in all but seven states use specialty differentials. Because carriers have discretion in establishing

---

1 A specialty differential is a difference in the prevailing charge for different physician specialists for services designated by the same procedure code. For example, a service, such as an electrocardiogram, may have different payment rates depending on whether the service is provided by a general practitioner or a cardiologist.

2 The prevailing charge is one of the rates used to determine the amount a physician is paid for a service. It is calculated as the 75th percentile of the distribution of customary charges for physicians in a locality. In some cases, where the carrier uses specialty differentials, a separate prevailing charge is calculated for each discrete group of specialists that comprise the specialty differential.

3 Medicare carriers are private contractors to HCFA who reimburse physician claims under Medicare. There are 56 carriers nationwide.

prevailing charges, there is no uniformity in defining which groups of physicians should be placed in which specialty category. This creates increased administrative complexity for the program and results in payment differences for physicians providing the same services.

Criticism of the current use of specialty differentials comes from Congress, the Physician Payment Review Commission, and physician organizations. HCFA is currently examining whether to eliminate or modify the use of specialty differentials in establishing prevailing charges. Thus information is needed on what the financial impact would be on Medicare Part B expenditures and on individual physician specialties.

This paper answers the question: what is the financial impact of moving from reimbursing physicians based on multiple prevailing charges for a single service using specialty differentials to reimbursing a single prevailing charge per service? It presents background on current physician reimbursement under Medicare; estimates the financial impact on the Medicare program nationally and for six states, as well as the impact on different physician specialties; and describes the data sources and methods used to answer the question.

Moving from multiple prevailing charges based on specialty differentials to a single prevailing charge per service would be budget neutral and not change overall Medicare Part B expenditures, when a blended prevailing charge is calculated. In the six states examined (California, Illinois, Massachusetts, New Jersey, Oregon, and Texas), the impact on Medicare outlays is also budget neutral, since the single prevailing charge is computed on a locality-specific basis.

A. BACKGROUND

Medicare reimburses physicians on a fee-for-service basis according to the customary, prevailing, and reasonable (CPR) system. Medicare reimburses a claim based on the lowest of four alternative rates:

- Physician's submitted charge.
- Physician's customary charge, defined as the median charge for that service during the previous year.
- "Unadjusted" prevailing charge defined as the 75th percentile of the distribution of customary charges for all physicians in the locality.
- "Adjusted" prevailing charge, defined as the prevailing charge applicable in June 1973, inflated by the Medicare Economic Index (MEI).

On average approximately 51 percent[4] of Medicare claims are reimbursed at the prevailing charge, and of these fewer than one-half are set at the MEI-adjusted prevailing charge. Any change in the prevailing charge would affect those claims currently paid at the unadjusted prevailing charge as well as claims that were paid at actual or customary charges for individual physicians that would now be paid at the new prevailing charge.

Fifty-six different Medicare carriers reimburse physicians for services provided to Medicare beneficiaries. These carriers determine the specialty differentials that are used to create the prevailing charge. HCFA allows carriers wide discretion in establishing specialty differentials, and there is no uniform federal policy for setting prevailing charges by specialty.[5] As a result, patterns of using specialty differentials vary widely and are employed inconsistently among carriers. They have discretion in determining the members of a specialty group. For example, they determine whether all specialty groups should have a separate prevailing charge or whether internists should be combined with general cardiologists or general practitioners. They determine whether existing patterns of charges for a specific service are sufficiently different to warrant separate prevailing charges for a specialty and determine the methods for establishing specialty differentials. Carriers also vary widely in how many different specialties they recognize with separate prevailing charges. Seven carriers have one charge for each service, others have two or three separate charges, and a few have as many as 30 charges for a single service.

The result of these specialty differentials is that for some services physicians with equal customary charges are reimbursed different amounts for providing the same service. For example, the customary charge for an internist and a cardiologist may be $40 for an office visit. However, the physicians may be in different specialty groups for purposes of computing the prevailing charge. As a result, the prevailing charge for the internist may be $35 while the prevailing charge for the cardiologist may be $40 for the same office visit.

For those services that are always performed by a single specialty, the specialty differential does not pose a problem. For those services that are performed by many different physician specialties, such as office visits and consultations, specialty differentials can result in different payment practices. These differentials pose a particular problem for primary care physicians because the bulk of their work consists of office visits and consultations, and their prevailing charges are often lower than other specialists. This may create a disincentive for physicians to enter primary care specialties, such as family practice, because they know that most

---

4 Congressional Budget Office tabulations from 1984 Health Care Financing Administration data in Physician Reimbursement Under Medicare: Options for Change. April, 1986.

5 A 1984 GAO study found that little or no analysis had been conducted by carriers to support specialty differentials.

services for a Medicare beneficiary, will be reimbursed at less than other specialists for the same service.

Specialty differentials may also result in higher beneficiary out-of-pocket costs for using some specialists as opposed to others. For example, if a family physician and an internist both charge $50 for an office visit and the prevailing charge is $30 and $45 respectively, the beneficiary would incura higher out-of-pocket cost by seeking care from a family physician compared to an internist.[6]

The issue of specialty differentials has been argued in the courts. In 1979 the Michigan Academy of Family Physicians filed suit against Michigan Blue Shield (the Medicare carrier) challenging the use of specialty differentials in establishing prevailing charges. The Michigan court ruled that the establishment of different prevailing charges for the same service based on the specialty of the physician violates the Medicare statute. This decision was appealed by the federal government and sustained by the U.S. Sixth Circuit Court of Appeals. Finally, the U.S. Supreme Court ruled that courts have jurisdiction in cases involving Part B Medicare reimbursement disputes and upheld the Michigan court's verdict.

B. RESULTS OF THE ANALYSIS

Reimbursing physicians based on a single prevailing charge would be budget neutral using a blended prevailing charge based on the weighted average of the volume of claims in each specialty in 1985. The change in Medicare expenditures for the states we examined would also be budget neutral.

In computing a budget neutral blended prevailing charge, the prevailing charge of some specialists would increase while others would decrease. Nationally, family physicians, general practitioners, and general surgeons would experience an increase in prevailing charges of 9.98 percent, 8.40 percent, and 9.02 percent, respectively. Internists, general cardiologists, and the aggregate of all other specialists[7] would experience a decrease in prevailing charges of 3.45 percent, 12.79 percent, and 3.08 percent, respectively (see Table 1). (The change in prevailing charges for general surgeons and general cardiologists may be overstated because these physicians have a low volume of claims in the services that represent the bulk of family physicians' practice. As described in the section on methods, these specialists have a smaller portion of their practice that is attributed to the 68 services examined in this analysis.)

---

[6] Beneficiary out-of-pocket costs are only higher if the physician does not "accept assignment". If a physician accepts assignment the Medicare payment for the service is considered payment in full. Currently approximately 70 percent of claims are submitted as assigned claims.

[7] Includes all other specialists, such as OB/GYN physicians, pediatricians, radiologists, neurosurgeons, and gastroenterologists.

The change in prevailing charges represents the maximum increase or decrease in Medicare payments to different physician specialties resulting from moving to a single prevailing charge. This is because changes in Medicare payments are related to the proportion of claims paid at the prevailing charge. For example, if all claims were reimbursed at the prevailing charge, then the increase/decrease in Medicare payments for physicians would equal the change in the prevailing charge (e.g., 9.98 percent for family physicians). On the other hand, if, as we know, approximately 51 percent of claims are reimbursed at the prevailing charge, then the change in Medicare payments would be 51 percent of the change in prevailing charges (e.g., .51 X 9.98 or 5.09 percent for family physicians).[8]

The state-specific changes in prevailing charges for different specialties vary widely (see Table 2). The change in prevailing charges for family physicians would range from a decrease of 4.9 percent in Oregon to an increase of 14.25 percent in Massachusetts. General practitioners consistently would experience an increase in prevailing charges ranging from .04 percent in Oregon to 18.02 percent in Illinois. Internists would experience a decrease in prevailing charges ranging from 2.13 in Oregon to 17.16 in New Jersey. Prevailing charges for general surgeons would increase in four of the states and decrease in California and New Jersey. Prevailing charges for general cardiologists decrease in all states examined except Massachusetts.

The variation among states in changes in prevailing charges to different specialists is related to how states determine specialty differentials, the volume of claims submitted by different specialties, and the distribution of customary charges in the state. For example, in a state with a large number of specialty differentials, such as Massachusetts, we would expect to observe large changes in prevailing charges among different specialties because moving from 25 prevailing charges to a single prevailing charge would produce large changes in the specialties in the upper and lower end of the distribution. In addition, the more services are affected by the change in the prevailing charge, the greater the change in payment observed. Finally, if the variation in the customary charges among specialties in a state is small, then we would expect small changes in prevailing charges among specialties by moving to a single prevailing charge. Disaggregated carrier-specific data are not available to permit examination of the reasons for the findings in each state.

Whether or not a specialty would experience an increase or decrease in the prevailing charge varies by service (see Table 2). For example, family physicians would experience an increase in the prevailing charge for 87 percent of the services examined, while the prevailing charge for internists would increase for only 22 percent of the services. The impact of these changes on Medicare payments depends on the volume of claims a specialty submits for a particular service, the customary charge of different specialties for a given service, and the proportion of claims reimbursed at the prevailing charge.

---

[8] The proportion of claims paid at the prevailing charge varies by service and specialty. The BMAD procedure and prevailing files do not provide information on the proportion of claims paid at the prevailing charge by specialty.

C. METHODS

Data for the analysis is from the HCFA 1985 Part B Medicare Annual Data (BMAD) procedure and prevailing files. These files contain data on all procedures in the CPT-4 coding system. For each procedure and physician specialty we examined data by locality on the volume of claims, prevailing charges, and the total dollars approved by Medicare. The procedure and prevailing files were matched to provide information on the allowed charges for each service with the old and new prevailing charges. Data from 29 of the 56 carriers were excluded in the matched data set because of reporting problems at the carrier level. The excluded carriers should not bias the analysis, since the representation of specialists was the same in those carriers included in the analysis and those carriers excluded.

For ease of analysis, the top 68 services (ranked by total allowed amounts and volume of claims in 1985) were used in the analysis. The services accounted for 68 percent of all Medicare charges for family physicians and 59 percent of all claims (see Table 3). Procedure codes with "modifiers" attached were eliminated to ensure that a homogenous set of services was described by a given procedure code. (Modifiers are used to indicate the presence of unique characteristics associated with a claim, and should be deleted because they represent outliers.)

Six states, California, Illinois, Massachusetts, New Jersey, Oregon, and Texas, were examined to analyze the impact of adopting a single prevailing charge. The criteria for selecting the states included geographic representation, variation in size, and a large volume of claims.

The new blended prevailing charge for each service was calculated by weighting the prevailing charges for each specialty by the volume of services performed by the specialty. The prevailing charge was budget neutral nationwide; that is, aggregate Medicare costs nationwide would be unchanged by the payment rates, although the distribution of payments across practices might change.

In order to estimate the relative impact of a single prevailing charge across different physician specialties, we developed a Laspeyres index. In economic terms, a Laspeyres index is a fixed-price index to compare bundles of goods. For our index, we compared bundles of services (the 68 top services for family physicians) across physician specialties. Because of inconsistent carrier reporting along with the prevailing charge and procedure files matching process, no one locality in our sample contained each of the 69 services. Therefore, using the Laspeyres index we adjusted the relative volume of services in the national and state estimates to compensate for the missing services.

The methods used to conduct the analysis are likely to accurately reflect the impact of moving to a single prevailing charge for family physicians and general practitioners, but may slightly overstate the impact on other specialists. By using the top 68 procedures for family physicians we capture the bulk of their practices, but capture a smaller portion of the practices of other physicians, such as general cardiologists. How much overstatement results depends on the specialty differentials used to determine the prevailing charge for the services most common to these specialists. For example, the impact on internists is likely to be overstated in this analysis because they perform services for which the prevailing charge is less than other specialists.

Table 1

Maximum Change in Medicare Part B Payments
Under a Single Prevailing Charge
By Specialty[1]

Percent Change

Specialty	All Carriers[2]	California	Illinois	Massachusetts	New Jersey	Oregon	Texas
All Specialties	0	0	0	0	0	0	0
Family Practice	9.98	2.22	-1.52	14.25	4.95	-4.90	3.56
General Practice	8.40	2.60	18.02	11.13	8.00	.04	*
Internal Medicine	-3.45	-3.36	-8.55	-3.62	-17.16	-2.13	-4.80
General Surgery	9.02	-5.54	6.02	10.92	-3.17	.20	6.62
General Cardiology	-12.78	-17.64	-10.80	1.94	-21.67	-4.76	-23.08
Other Specialists	-3.08	4.24	3.42	-7.64	15.22	4.79	.43

1 Medicare payments are related to the proportion of claims paid at the prevailing charge. The numbers above assume 100 percent of claims are paid at the prevailing charge, and therefore represent a maximum change in Medicare payments. If, for example, 51 percent of the claims are paid at the prevailing charge, the change in Medicare payments would be 51 percent of the above numbers.

2 27 carriers. An additional 29 carriers were excluded from this study because of the carriers' reporting problems.

* Texas data excluded a specialty designation for general practice physicians.

Source: Lewin/ICF analysis of Part B Medicare Annual Data, Health Care Financing Administration, 1985.

Table 2

Percent of Sampled Services for which the Prevailing Charge Increases or Decreases, by Specialty

All Carriers

Specialty	Percent of Services for which Prevailing Charge Increases	Percent of Services for which Prevailing Charges Decrease
Family Practice	87%	13%
General Practice	66	34
Internal Medicine	22	78
General Surgery	79	21
General Cardiology	29	71
Other Specialists	47	53

Source: Lewin/ICF analysis of Part B Medicare Annual Data, Health Care Financing Administration, 1985

Table 3

FAMILY PHYSICIAN PROCEDURE SAMPLE

	PROCEDURE	ALLOWED DOLLARS	% OF TOTAL	CUM %	SUBMITTED CLAIMS	% OF TOTAL	CUM %	REIMBURSED CLAIMS	% OF TOTAL	CUM %
1	90050 OFFICE VISIT, ESTABLISHED PATIENT -- LIMITED SERVICE	$81,702,768	10.08	10.08	5,088,294	10.70	10.70	4,915,192	11.26	11.26
2	90060 OFFICE VISIT, ESTABLISHED PATIENT -- INTERMEDIATE SERVICE	$77,019,104	9.50	19.58	4,138,006	8.70	19.40	3,994,562	9.15	20.41
3	90260 SUBSEQUENT HOSPITAL CARE -- INTERMEDIATE SERVICE	$55,466,176	6.84	26.42	2,513,135	5.28	24.68	2,331,003	5.34	25.75
4	90250 SUBSEQUENT HOSPITAL CARE -- LIMITED SERVICE	$45,815,824	5.65	32.07	2,522,687	5.30	29.98	2,334,127	5.35	31.10
5	90220 INITIAL HOSPITAL CARE -- COMPREHENSIVE HISTORY	$36,860,336	4.55	36.62	684,175	1.44	31.42	651,797	1.49	32.59
6	90040 OFFICE VISIT, 'ESTABLISHED PATIENT -- BRIEF SERVICE	$30,646,240	3.78	40.40	2,215,156	4.66	36.08	2,133,778	4.89	37.48
7	93000 ELECTROCARDIOGRAM, UP TO 12 HOURS	$22,168,256	2.73	43.13	792,254	1.67	37.75	747,808	1.71	39.19
8	90240 SUBSEQUENT HOSPITAL CARE -- EACH DAY BRIEF SERVICES	$19,788,720	2.44	45.57	1,267,174	2.66	40.41	1,166,781	2.67	41.86
9	90070 OFFICE VISIT, ESTABLISHED PATIENT -- EXTENDED SERVICE	$16,489,538	2.03	47.61	684,409	1.44	41.85	656,671	1.50	43.36
10	90270 SUBSEQUENT HOSPITAL CARE -- EXTENDED SERVICES	$12,765,267	1.57	49.18	469,364	0.99	42.84	437,357	1.00	44.36
11	90080 OFFICE VISIT, ESTABLISHED PATIENT -- COMPREHENSIVE SERVICE	$10,684,945	1.32	50.50	308,543	0.65	43.49	292,779	0.67	45.03
12	90215 INITIAL HOSPITAL CARE -- INTERMEDIATE HISTORY	$9,886,644	1.22	51.72	214,329	0.45	43.94	204,721	0.47	45.50
13	71020 RADIOLOGICAL EXAM, CHEST -- 2 VIEWS, FRONT & LATERAL	$9,066,404	1.12	52.84	295,707	0.62	44.56	275,005	0.63	46.13
14	90292 HOSPITAL DISCHARGE DAY MANAGEMENT	$7,216,329	0.89	53.73	297,479	0.63	45.19	270,918	0.62	46.75
15	93274 ELECTROCARDIOGRAM, 12-24 HOURS	$6,019,432	0.74	54.47	33,170	0.07	45.26	29,666	0.07	46.82
16	90020 OFFICE VISIT, NEW PATIENT, COMPREHENSIVE SERVICES	$5,658,160	0.70	55.17	159,893	0.34	45.60	149,920	0.34	47.16
17	90360 SKILLED NURSING, SUBSEQUENT CARE, INTERMEDIATE SERVICE	$5,365,603	0.66	55.83	264,125	0.56	46.16	248,919	0.57	47.73
18	90350 SKILLED NURSING, SUBSEQUENT CARE, LIMITED SERVICE	$4,557,239	0.56	56.39	259,018	0.54	46.70	245,329	0.56	48.29
19	99160 CRITICAL CARE, INITIAL	$4,511,754	0.56	56.95	74,258	0.16	46.86	68,679	0.16	48.45
20	90450 NURSING HOME, ESTABLISHED PATIENT, LIMITED SERVICE	$4,140,701	0.51	57.46	257,368	0.54	47.40	237,370	0.54	48.99
21	90015 OFFICE VISIT, NEW PATIENT, INTERMEDIATE SERVICE	$4,131,708	0.51	57.97	167,842	0.35	47.75	156,778	0.36	49.35
22	90030 OFFICE VISIT, ESTABLISHED PATIENT -- LIMITED SERVICE	$3,939,104	0.49	58.45	352,943	0.74	48.49	338,094	0.77	50.12
23	90280 SUBSEQUENT HOSPITAL CARE -- COMPREHENSIVE SERVICE	$3,797,195	0.47	58.92	135,670	0.29	48.78	125,943	0.29	50.41
24	90200 INITIAL HOSPITAL CARE -- BRIEF HISTORY	$3,602,623	0.44	59.37	94,515	0.20	48.98	89,811	0.21	50.62
25	90460 NURSING HOME, ESTABLISHED PATIENT, INTERMEDIATE SERVICE	$3,415,950	0.42	59.79	175,198	0.37	49.35	160,014	0.37	50.99
26	90010 OFFICE VISIT, NEW PATIENT, LIMITED SERVICE	$3,304,418	0.41	60.19	157,184	0.33	49.68	147,826	0.34	51.33
27	90160 HOME MEDICAL SERVICES, ESTABLISHED PATIENT -- INTERMEDIATE SERVICE	$3,256,646	0.40	60.60	117,847	0.25	49.93	113,659	0.26	51.59
28	71010 RADIOLOGICAL EXAM, CHEST -- SINGLE VIEW, FRONTAL	$2,738,895	0.34	60.93	122,676	0.26	50.19	115,415	0.26	51.85
29	90620 INITIAL CONSULTATION, COMPREHENSIVE	$2,695,033	0.33	61.27	46,048	0.10	50.29	43,044	0.10	51.95
30	90150 HOME MEDICAL SERVICES, ESTABLISHED PATIENT -- LIMITED SERVICE	$2,644,642	0.33	61.59	104,237	0.22	50.51	99,579	0.23	52.18
31	45360 COLONOSCOPY, FIBEROPTIC	$2,628,009	0.32	61.92	16,727	0.04	50.55	16,149	0.04	52.22
32	99173 CRITICAL CARE, INTERMEDIATE EXAM	$2,390,790	0.29	62.21	71,968	0.15	50.70	65,043	0.15	52.37
33	45330 ENDOSCOPY, SIGMOIDOSCOPY	$2,204,963	0.27	62.48	29,556	0.06	50.76	28,472	0.07	52.44
34	M0040 BRIEF EXAM, TWO OR MORE PATIENTS, SAME NURSING HOME	$2,077,353	0.26	62.74	145,853	0.31	51.07	134,427	0.31	52.75
35	90517 EMERGENCY DEPARTMENT -- NEW PATIENT, EXTENDED SERVICE	$1,947,288	0.24	62.98	45,761	0.10	51.17	42,691	0.10	52.85
36	90515 EMERGENCY DEPARTMENT -- NEW PATIENT, INTERMEDIATE SERVICE	$1,902,197	0.23	63.21	71,662	0.15	51.32	67,498	0.15	53.00
37	20610 REMOVAL OF MAJOR JOINT OR BASE	$1,746,166	0.22	63.43	74,732	0.16	51.48	72,234	0.17	53.17
38	90340 SUBSEQUENT SKILLED NURSING CARE, BRIEF SERVICE	$1,736,954	0.21	63.64	121,763	0.26	51.74	111,579	0.26	53.43
39	90370 SUBSEQUENT SKILLED NURSING CARE, EXTENDED SERVICE	$1,735,603	0.21	63.86	66,447	0.14	51.88	62,033	0.14	53.57
40	90320 INITIAL SKILLED NURSING CARE, COMPREHENSIVE HISTORY AND EXAM	$1,668,730	0.21	64.06	38,415	0.08	51.96	36,024	0.08	53.65
41	P9600 ROUTINE VENIPUNCTURE FOR COLLECTION OF SPECIMEN	$1,614,687	0.20	64.26	573,586	1.21	53.17	542,595	1.24	54.89
42	90000 OFFICE VISIT, NEW PATIENT, BRIEF SERVICE	$1,565,507	0.19	64.46	90,704	0.19	53.36	86,120	0.20	55.09
43	99171 CRITICAL CARE, SUBSEQUENT FOLLOW-UP VISIT, BRIEF EXAM	$1,546,265	0.19	64.65	62,413	0.13	53.49	57,049	0.13	55.22
44	90440 NURSING HOME, ESTABLISHED PATIENT, BRIEF SERVICE	$1,544,282	0.19	64.84	109,492	0.23	53.72	98,991	0.23	55.45
45	90017 OFFICE VISIT, NEW PATIENT, EXTENDED SERVICE	$1,533,775	0.19	65.03	65,142	0.14	53.86	61,075	0.14	55.59
46	90510 EMERGENCY DEPARTMENT, NEW PATIENT, LIMITED SERVICE	$1,466,441	0.18	65.21	68,834	0.14	54.00	65,146	0.15	55.74
47	90250 SUBSEQUENT HOSPITAL CARE, LIMITED SERVICES	$1,435,300	0.18	65.39	66,229	0.14	54.14	63,043	0.14	55.88

Table 3 (cont.)

FAMILY PHYSICIAN PROCEDURE SAMPLE -- cont.

	PROCEDURE	ALLOWED DOLLARS	% OF TOTAL	CUM %	SUBMITTED CLAIMS	% OF TOTAL	CUM %	REIMBURSED CLAIMS	% OF TOTAL	CUM %
48	90170 HOME MEDICAL SERVICES, ESTABLISHED PATIENT, EXTENDED SERVICE	$1,407,430	0.17	65.56	45,567	0.10	54.24	43,827	0.10	55.98
49	45300 PROCTOSIGMOIDOSCOPY, DIAGNOSTIC	$1,400,668	0.17	65.74	41,808	0.09	54.33	39,985	0.09	56.07
50	W9045	$1,378,161	0.17	65.91	66,586	0.14	54.47	62,807	0.14	56.21
51	99174 CRITICAL CARE, SUBSEQUENT FOLLOW-UP VISIT, EXTENDED RE-EXAM	$1,288,962	0.16	66.06	35,983	0.08	54.55	32,963	0.08	56.29
52	99172 CRITICAL CARE, SUBSEQUENT FOLLOW-UP VISIT, LIMITED EXAM	$1,284,154	0.16	66.22	45,513	0.10	54.65	41,325	0.09	56.38
53	90315 INITIAL SKILLED NURSING CARE, INTERMEDIATE HISTORY AND EXAM	$1,258,127	0.16	66.38	38,801	0.08	54.73	37,128	0.09	56.47
54	94010 SPIROMETRY, INCLUDING GRAPHIC RECORD	$1,133,948	0.14	66.52	40,208	0.08	54.81	38,261	0.09	56.56
55	93010 ELECTROCARDIOGRAM, INTERPRETATION AND REPORT ONLY	$1,112,201	0.14	66.65	100,860	0.21	55.02	94,773	0.22	56.78
56	94060 BRONCHOSPASM EVALUATION	$1,107,680	0.14	66.79	20,394	0.04	55.06	19,554	0.04	56.82
57	M0030 LIMITED EXAM, TWO OR MORE PATIENTS, SAME NURSING HOME	$1,093,222	0.13	66.93	82,584	0.17	55.23	75,707	0.17	56.99
58	90470 NURSING HOME, ESTABLISHED PATIENT, EXTENDED SERVICE	$1,090,736	0.13	67.06	45,480	0.10	55.33	41,608	0.10	57.09
59	99162 INITIAL CRITICAL CARE, ADDITIONAL 30 MINUTES	$962,966	0.12	67.18	27,521	0.06	55.39	26,005	0.06	57.15
60	99000 TRANSFER OF SPECIMEN FROM OFFICE TO LAB	$932,814	0.12	67.29	410,180	0.86	56.25	308,574	0.71	57.86
61	90140 HOME MEDICAL SERVICES, ESTABLISHED PATIENT, BRIEF SERVICE	$910,361	0.11	67.41	41,110	0.09	56.34	39,024	0.09	57.95
62	92950 CARDIOPULMONARY RESUSCITATION	$859,521	0.11	67.51	7,761	0.02	56.36	7,199	0.02	57.97
63	93015 CARDIOVASCULAR STRESS TEST USING TREAD MILL	$844,102	0.10	67.62	8,902	0.02	56.38	8,103	0.02	57.99
64	72110 RADIOLOGICAL EXAM, COMPLETE WITH OBLIQUE VIEWS	$841,042	0.10	67.72	16,748	0.04	56.42	16,064	0.04	58.03
65	72100 RADIOLOGICAL EXAM, SPINE, LUMBOSACRAL	$837,512	0.10	67.82	23,336	0.05	56.47	22,443	0.05	58.08
66	90420 NURSING HOME, NEW PATIENT, COMPREHENSIVE SERVICE	$827,625	0.10	67.93	21,575	0.05	56.52	20,117	0.05	58.13
67	90560 EMERGENCY DEPARTMENT, ESTABLISHED PATIENT, INTERMEDIATE SERVICE	$807,214	0.10	68.03	38,643	0.08	56.60	36,300	0.08	58.21
68	36415 ROUTINE VENIPUNCTURE FOR COLLECTION OF SPECIMEN	$791,568	0.10	68.12	264,125	0.56	57.16	255,167	0.58	58.79

Item 6

AMERICAN ACADEMY OF OPHTHALMOLOGY

June 14, 1988

Senator John Melcher
Chairman
Senate Special Committee
on Aging
Attention: Holly Bode
Room G-41
Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Melcher:

Thank you for inviting the American Academy of Ophthalmology to submit comments to your Committee's study of physician payment issues under the federal Medicare program. The Academy represents more than 16,000 or 96% of the eye physicians and surgeons in the U.S.

Resource-Based RVS. We have some specific concerns regarding the current Harvard relative value study. These are summarized in our attached statement to the House Ways and Means Committee, as follows:

- Every relative value scale primarily mirrors the researcher's assumptions and selection of values for measurement, which may affect the resulting scale even more than data quality and analytical soundness.
- Use of a RVS-derived fee schedule would merely re-allocate the same amount of reimbursement funds among the same number of physicians; it would not reduce Medicare expenditures.
- Before basing public policy on a particular RVS, there must be debate and agreement on the assumptions and values, as well as the data and analysis.
- When the Harvard resource-based RVS is completed this July, the researcher's assumptions and values must be scrutinized and the data analysis evaluated.

We wish to point out that representatives of ophthalmology and other physician groups did not participate in the Harvard RVS project during the vital

SECRETARIAT FOR GOVERNMENTAL RELATIONS

HUNTER R. STOKES, M.D.
Secretary
Post Office Box F-17
602 East Cheves Street
Florence, South Carolina 29501

ALLAN D. JENSEN, M.D.
Associate Secretary for Federal Economic Policy
14 West Mount Vernon Place
Baltimore, Maryland 21201

MICHAEL A. LEMP, M.D.
Associate Secretary for Research, Regulatory Agencies and Federal Systems
Center for Sight
Georgetown University Medical Center
3800 Reservoir Road, N.W.
Washington, D.C. 20007

DAVID W. PARKE, M.D.
Associate Secretary for State Affairs
477 South Broad Street
Meriden, Connecticut 06450

ARTHUR M. REYNOLDS, JR., M.D.
Associate Secretary for Federal Legislation
1515 Chain Bridge Road
McLean, Virginia 22101

OFFICE OF GOVERNMENTAL RELATIONS

CYNTHIA C. ROOT
Director
1101 Vermont Avenue, N.W.
Suite 300
Washington, D.C. 20005-3570
(202) 737-6662

period when the project's assumptions were being established. Nevertheless, ophthalmologists did cooperate up to the limited extent permitted by the Harvard project staff. There is a fundamental and critical difference between active participation and reactive cooperation.

Specialty Differentials. You also requested our response to the Health Care Financing Administration's proposal to consider eliminating the current differential in payment levels under Medicare between specialists and generalists. As you will note from our attached letter of comment on HCFA's April 12 notice, we are generally opposed to making a change in the current calculations.

First, we believe that specialists have a higher level of training and tend to see patients with more severe health conditions than non-specialists. Second, we believe that there should be stronger distinctions between medical doctors and non-medical doctors who bill under the same code.

Finally, we do not believe that HCFA has presented any evidence that the current specialty differentials are creating any problems. Changing the current fee structure at this time is likely to be very disruptive, and seemingly without justification.

Again, thank you for this opportunity to comment. We would be happy to meet with you or your staff to provide any further assistance we could offer.

Sincerely,

Hunter Stokes, MD
Secretary

AMERICAN ACADEMY OF OPHTHALMOLOGY

SECRETARIAT FOR
GOVERNMENTAL RELATIONS

HUNTER R. STOKES, M.D.
Secretary
Post Office Box F-17
602 East Cheves Street
Florence, South Carolina 29501

ALLAN D. JENSEN, M.D.
Associate Secretary for
Federal Economic Policy
14 West Mount Vernon Place
Baltimore, Maryland 21201

MICHAEL A. LEMP, M.D.
Associate Secretary for
Research, Regulatory Agencies
and Federal Systems
Center for Sight
Georgetown University Medical Center
3800 Reservoir Road, N.W.
Washington, D.C. 20007

DAVID W. PARKE, M.D.
Associate Secretary for
State Affairs
477 South Broad Street
Meriden, Connecticut 06450

ARTHUR M. REYNOLDS, JR., M.D.
Associate Secretary for
Federal Legislation
1515 Chain Bridge Road
McLean, Virginia 22101

OFFICE OF
GOVERNMENTAL RELATIONS

CYNTHIA C. ROOT
Director
1101 Vermont Avenue, N.W.
Suite 300
Washington, D.C. 20005-3570
(202) 737-6662

June 13, 1988 HAND DELIVERED

Health Care Financing Administration
DHHS, Attention BERC-455-NI
Room 309-G, Humphrey Bldg
200 Independence Ave. SW
Washington, DC 20201

Re: April 12 rules on discontinuing charge differentials for specialists

Dear Sirs:

The American Academy of Ophthalmology wishes to comment on the April 12 proposal to eliminate specialty prevailing charge screens under Medicare (BERC-455-NI). The Academy represents 16,000 or 96% of physicians who specialize in the medical and surgical treatment of the eye.

At this time, we are generally opposed to changes in the calculation of Medicare prevailing or other charges that would eliminate distinctions among specialists and non-specialists. We would recommend that stronger distinctions be made, especially to assure distinctions in data gathering for non-M.D.s performing similarly coded services.

Specialists fees should not be changed at this time, since physicians have just made their decisions regarding Medicare participation, based on the prevailing rates and MAACs provided by their carriers in March, 1988. Many of the carriers are still overburdened with recalculation of incorrect or incomplete MAACs, and with implementing the significant requirements imposed by recent law.

Since very few other medical doctors do a substantial segment of eye care, the specialist/non-specialist differential issue is not as central to ophthalmology per se as it may be to other specialties. We do, however, have substantial concerns about non-M.D. providers.

In the few areas where M.D.s do provide eye care, for example in treating conjunctivitis, the equipment, type and comprehensiveness of the examination are distinctly different in scope. Therefore, we feel there is a difference in the level of service, e.g., the use of a slit lamp and epithelial staining in the evaluation of a red eye carried out by the ophthalmologist versus the flashlight exam by a non-ophthalmologist medical doctor or by an optometrist.

The following are our responses to your particular request for comments:

1. What impact would eliminating the specialty-specific screens have on services, especially primary services in rural and urban areas.

We are not aware of any assessment of the impact of eliminating the specialty differentials. However, it seems reasonable to expect that it would have very little impact in raising the fees for primary care, and a much greater impact in lowering the fees of specialists.

2. Similarity and Differences in Visit and Consultation Services.

We believe that there are important differences in visits and consultations between specialists and non-specialists, and such differences are currently reflected in the CPT codes for ophthalmological procedures as compared to general medical office visit codes. However, we feel that HCFA must make greater efforts to assure the distinctions in services allowed, and data gathered in regard to non-M.D.s who might use ophthalmologic codes.

3. The need, if any, to use different codes or modifiers and terminology to describe services in ways that make needed specialty distinctions.

We believe that every effort should be made to maintain the distinction in services among physicians, and between physicians and non-M.D.s.

We recommend that HCFA prohibit the use of codes that would unbundle the global fee for cataract surgery for the purpose of allowing optometrists to care for patients before the end of the post-operative recovery period. Only the operating surgeon, or another medical doctor of equal training and competence can adequately care for a cataract patient during the post-operative period.

In general, HCFA should not permit optometrists to use any ophthalmologic visit or procedure codes. Optometric billing should be allowed only under general visit codes, with clear distinctions as to their non-M.D. status.

4. Permitting carriers to maintain separate prevailing charge screens for specific specialties or groups of specialties for medical visits and consulations.

We believe that specialists provide the patient with the benefit of extra training, and that in consultations and visits, are likely to evaluate, diagnose and treat patients with more severe health conditions than non-specialists, and certainly more so than non-M.D.s.

Furthermore, HCFA has not presented any evidence that the specialty differentials are creating any problems. Changing the current fee structure to eliminate differentials is likely to be very disruptive to specialists, and seemingly without justification.

We believe that the carriers have enough of a burden in carrying out accurate MAAC and prevailing fee calculations, as well as all the other requirements for data collection, review and prompt payment. No change in policy should be allowed at this time.

Thank you for this opportunity to comment.

Sincerely,

Allen Jensen, MD
Associate Secretary for Federal
Economic Policy

Item 7

THE AMERICAN ACADEMY OF OTOLARYNGOLOGY—HEAD AND NECK SURGERY, INC.

1101 VERMONT AVENUE, N.W., SUITE 302, WASHINGTON, D.C. 20005-3521 (202) 289-4607
FAX (202) 289-5242 • ELECTRONIC BULLETIN BOARD (202) 289-7338

June 1, 1988

Special Committee on Aging
U.S. Senate
Dirksen G-41
Washington, DC 20510-6400

Attn: Ms. Holly Bode

Dear Members of the Committee:

The American Academy of Otolaryngology - Head and Neck Surgery appreciates the opportunity to submit the statement below for inclusion in your report on physician payment issues.

At the outset, we would like to place the issue of reimbursement for physicians' services in the context not only of fairness and adequacy from the provider's point of view, but in the larger context of access to high quality medical care. Medicine must provide both the professional autonomy and economic incentives to attract the gifted, and it must attract the gifted in sufficient numbers to ensure that an increasingly older population has access to physicians. We recognize the need to constrain spending. We also recognize that efforts to restrain spending on physician services must not result in excessive constraints upon the use of the highest quality therapies and modalities of treatment, or, upon access.

The Committee has specifically asked for our response to the release of the Physician Payment Review Commission's second annual report to Congress. Very generally, we are pleased at the PPRC's endorsement of the continuation of fee-for-service medicine in the form of a resource-based relative value scale. It is particularly reassuring that the PPRC plans a critical evaluation of the relative value scale study to be submitted to Congress by William Hsiao, Ph.D. As a result of our specialty's active participation in the Hsiao project, we have serious concerns regarding the data-gathering and analytic methods of Dr. Hsiao. The PPRC's awareness of the complexity of measuring the physician's time and effort for various services is extremely well placed. Similarly, the PPRC's sensitivity to geographical differences in cost of practice is welcome (although the Commission's focus on an index of non-physician earnings as a basis for a geographic multiplier may not be justifiable).

Your Committee has also asked for our response to the Health Care Financing Administration's interest in reordering the existing physician payment system as noted in the April 12 Federal Register. We agree that there is no justification for the existence of different prevailing charges for, e.g., a general plastic surgeon performing a rhytidectomy versus an otolaryngologist performing the same procedure. We also agree that different specialty screens are superfluous for procedures performed uniquely by one specialty (we are somewhat concerned, however, that the reduction of a prevailing charge for a procedure performed by multiple specialties would be extrapolated to procedures performed by a single specialty without consideration of the resources involved).

We will not recommend that HCFA (or Congress) retain or elaborate specialty differentials in order to distinguish between a medical office visit to an internist and a medical or diagnostic office visit to a surgical specialist. It would be difficult enough to compare the resources, equipment, and total time used by an otolaryngologist in providing "extended" service (CPT 4 90017) to a new patient being evaluated for a rhinoplasty with the "extended" service provided to a second new patient (also using CPT 4 90017) in evaluating hearing loss. The latter would encompass basic comprehensive audiometry, impedance, tympanometry, acoustic reflex and acousting reflex decay testing. In order to amortize properly the cost of the different equipment used by different specialists for different patients, it might be best to base a generic office visit code or fee on the amount of physician time, with separate specific billing for the various diagnostic or therapeutic services provided in the course of that visit.

Whatever new methods of compensating physicians Congess ultimately endorses, we very much hope that there will be less finger-pointing. The admittedly steep rise in Medicare Part B outlays is not due to physician avarice - (the ideal reimbursement system would, of course, discourage extreme variability in fees not warranted by geographic or experiential differences). Rather, Congress and the public must be made aware of the shifting of costs from Part A to Part B through tighter hospital admission and discharge standards, and the concomitant rise in outpatient care, as well as through the transfer of laboratory testing costs to Part B. As this Committee is well aware, the aging population in and of itself increases demand for medical services--appropriately. There are other otolaryngic disorders affecting the elderly which will increase the volume of patients our specialists will see. These include problems with swallowing, voice, smell and taste, head and neck cancer and cosmetic concerns. This growth in the number of elderly patients requiring otolaryngology services means that Congress will at some point need to address the issue of whether to subsidize care for hearing loss and these other disorders, or whether to continue to place the out-of-pocket burden upon Medicare beneficiaries themselves.

We also stress that it is unfair to attribute the recent sudden rise in Medicare premiums to inflation of physicians fees, given the artificial restraint upon any such fee increases for a period of three to four years. Finally, we would like to register our ongoing protest at medicine's being the only profession or occupation whose fees are dictated by the government.

Again, gentlemen, we would like to thank you for having afforded us this opportunity to express our views. We look forward to responding to any further questions that the Committee might have.

Very truly yours,

Jerome C. Goldstein, M.D., F.A.C.S.

cc: Karin Bierstein, J.D., M.P.H.
John H. Boyles, Jr., M.D.
Lee van Bremen, Ph.D.

Item 8

American College of Cardiology

HEART HOUSE 9111 OLD GEORGETOWN ROAD BETHESDA, MARYLAND 20814 (301) 897-5400
800-253-4636
FAX (301) 897-9745

June 8, 1988

The Honorable John Melcher
United States Senate
Washington, D.C. 20510

Dear Senator Melcher:

We have received your letter concerning the Senate Special Committee on Aging's interest in physician payment issues. Clearly, this is a subject of great importance to Medicare beneficiaries, all levels of government, as well as the professional community. We sincerely appreciate the opportunity for the American College of Cardiology to submit a statement for inclusion in the Committee's report.

The College is in the process of preparing background papers and position papers on the subject of physician reimbursement. Unfortunately, at the present time, we have not prepared a formal response to the PPRC's Annual Report to Congress. We are actively considering reponding to the April 12 Federal Register request for comment issued by the Health Care Financing Administration.

As our public statements become available, we will be happy to share them with you and your Committee. While I am not able to predict the availability of statements by your publication date, I hope that we will be able to provide you with more specific information in the near future.

Thank you for your interest in the American College of Cardiology. We will look forward to working with you and your Committee in the future.

Sincerely,

Anthony N. DeMaria

Anthony N. DeMaria, M.D., F.A.C.C.
President

AND:mem:es

Item 9

Statement of the American College of Surgeons
to the
Senate Special Committee on Aging
on
Physician Payment Reform
June 1, 1988

The American College of Surgeons (ACS) is a voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high-quality care for the surgical patient. The College provides extensive educational programs for its 48,000 Fellows and for other surgeons in the United States. In addition, the College promotes standards for surgical practice, disseminates medical knowledge, and provides information to the general public.

The College has given a great deal of study to many of the physician payment issues being discussed by the Congress and in the Executive Branch of the government. On several occasions over the last few years, representatives from the College have appeared before Congressional committees and the Physician Payment Review Commission (PPRC) to share its views about various issues.

Throughout this process, the aim of the College has been to identify ways to establish a more rational basis for paying for physicians' services under Medicare without compromising access of beneficiaries to high-quality medical and surgical services. The College believes, however, that any initial steps toward improvement in Medicare's physician payment rules must be selected with care. Efforts should be made, insofar as possible, to avoid unduly sharp adjustments in payment policies or levels that might disrupt the continued availability of needed physicians' services for patients. Moreover, changes should not be influenced by expedient budgetary objectives.

The College has identified four broad policy goals that can be used as a guide in formulating changes in Medicare's payment principles for physicians' services. These are:

- To avoid, as much as possible, changes in payment methodology that would have undesirable consequences for beneficiaries from the standpoint of (a) loss of access to care, (b) compromises in quality of care, or (c) burdensome increases in beneficiary costs;

- To support the best practice of medical care and encourage continued improvements in clinical diagnosis and treatment;

- To make future costs of services more predictable and acceptable; and,

- To support a system of reimbursement that will ensure effectiveness and fairness of implementation and will reduce unnecessary administrative paperwork for both patients and physicians.

The hearings conducted by the Senate Special Committee on Aging make it apparent that our collective knowledge of the reasons for increases in the costs of physicians' services under Medicare is still incomplete. The usual analysis cites three broad factors in evaluating growth in program spending for physicians' services: price increases, enrollment growth, and increases in the volume of services per enrollee.

All of the recent attention to physician payment issues has focused on the price levels for physicians' services and the establishment of some sort of Medicare fee schedule, even though during much of the time there has been a freeze on physicians' charges. Between 1975 and 1985, the most important factor in the growth of expenditures was an increase in the volume of services, either for new enrollees or for more services per enrollee. We wish to point out that, in our view, much of the rise in the volume of services represents the use of new medical and surgical technologies and techniques that enhance the quality of life. These improvements--representing the provision of increasingly better care for more beneficiaries--should not be lost sight of in evaluating how well Medicare has performed in meeting the needs of older Americans. Steps to control the volume of services are closely linked to issues of patient access and quality of care and should be evaluated carefully by policymakers before any changes are adopted.

Nevertheless, the College supports a number of changes in Medicare's payment system that help respond to the volume issue. Surgeons bill for bundles of services by charging global fees that cover not only the operation itself, but also the related preoperative care and a defined amount of postoperative care of the patient. The College believes that the bundling

concept is a viable means of addressing some of the concerns about the volume of physicians' services and that this concept could be applied equally to both surgical and non-surgical services under Medicare.

The American College of Surgeons also believes that better definitions of physicians' services must be an essential part of an improved payment system. While Medicare now uses a common coding system and nomenclature, the coded services still lack precise and uniform definitions throughout the program's carrier-administered system. This variance has complicated the ability to compare payment amounts in one area with those in another, since payment differences simply may reflect differences in the scope of the services covered by the global fee even though the care provided in each locale is identified by the same service code.

Another dimension of the fee variation issue relates to different payment levels for those physicians considered specialists under the program. The College has considered whether specialty differentials should be maintained for payment purposes and, if so, in what manner. ACS is now considering its response to a request for comments on these matters recently made by the Health Care Financing Administration (HCFA).

It is the College's view that recognizing the services of specialists is appropriate, but that it should be done in a manner that is more rational than is now the case under Medicare. At present, carriers apply widely varying policies relating to payments for specialists' services that can yield inconsistent payment results. ACS believes that the principal reason for a differential is that some services are qualitatively different when performed by an appropriately trained specialist. In order to maintain high-quality care under the program, payment distinctions should be made between the services provided by an appropriately trained specialist and non-specialist.

Present policy also permits individual Medicare carriers to set Medicare-allowed charges independently, and the resulting geographic variation in allowed payments for the same service sometimes appears irrational. The College believes that any effort to revise Medicare's payment approach should take into account the specific reasons for some of these regional differences, including professional liability insurance costs and overhead expenses.

There has been a great deal of discussion about the use of a fee schedule in the Medicare program, and the College agrees that a fee schedule could respond to some of the perceived problems with the program's current payment rules, such as the fee variation problem. As one means of reducing fee variations, the College supports a Medicare relative value scale that recognizes the importance of the marketplace in setting payment amounts. This approach will help ensure that Medicare's levels of payment take into account payments made by insurers for the care of other patients in the community. The intent is to avoid a two-tiered medical care system--one for younger patients and another for the elderly.

The College supports the goal of establishing one Medicare relative value scale nationwide but is concerned that implementation of such a plan could result in serious disruption of physicians' services in some areas if proper precautions are not taken. The College believes that the development of statewide market-based relative value scales will allow a more gradual approach to achieving a single national relative value scale and will help gain the cooperation and acceptance of such changes by both Medicare patients and physicians.

The College is concerned about the PPRC's recent, premature endorsement of a Medicare fee schedule based on "resource costs" as the means for establishing the relative value of physicians' services. Some of our reservations about this recommendation are conceptual, while others stem from the uncertainties about the results that such an approach may yield for patients and for the health care system. Neither the Commission nor the Congress has yet received the results of the government-funded project concerning a resource-based approach for setting relative values. Nor has HCFA had an opportunity to evaluate the result of that effort.

Relative value scales, in themselves, of course, will not necessarily save money. Information concerning the potential multiplier(s) used to convert values to fees still is needed to determine what effect a resource-based approach may have on spending for physicians' services. The College takes the position that there is much yet to be done in evaluating the use of a resource-based relative value scale in the Medicare program and that consideration also must be given to alternative approaches to establishing a fee schedule.

The American College of Surgeons is appreciative of this opportunity to share its views on Medicare physician payment reform issues.

Item 10

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Special Committee on Aging
United States Senate

RE: Physician Payment Issues

June 1, 1988

The American Medical Association is pleased to provide this statement for the Aging Committee's Report on Physician Payment Issues. At the outset, it is important to point out that physician reimbursement cannot be viewed in a vacuum, and that physician services are provided in direct response to very personal needs that are essential to an individual's well-being.

It is important that we not lose sight of the great advances that have characterized our nation's health care system and the benefits that have been provided to our society. It is equally important for us to realize that future health advances will be affected by today's actions on issues such as physician reimbursement.

The remarkable achievements in medical care have not come without cost. Our commitment to quality health care for all is placing financial strains on the government and private sector alike. In addition, medical advances have created profound new moral dilemmas for which we still grope for answers. Our new ability to keep terminally-ill patients alive for indefinite periods of time and our ability to maintain life in premature and severely-handicapped infants are issues that will cause much societal and individual soul-searching in the years ahead.

Another factor that must be considered is the uncertainty of health care needs and predictions. Just a few short years ago, the death toll from and the money spent to combat AIDS was not even considered when witnesses discussed the future health care needs of our nation. As a compassionate people, we must not let the dollars spent for care cloud the real value of the care provided or limit access to that care.

The moral and economic consequences of these advances in medical technology are profound and must be addressed. However, they should be addressed within an atmosphere of reasoned policy determination that considers all elements of society's obligations to its members.

Inflation, Aging, and Liability Costs

Health care costs are not immune to outside market forces. A significant percentage of health care cost increases is attributable directly to continued inflation that has become a permanent fixture of our economy. According to an article published in the Summer 1987 issue of HCFA's Health Care Financing Review, general inflation accounted for approximately 32% of the increase in total system costs (personal health care costs) for the period of 1966 to 1986. In addition, approximately 11% of the growth in expenditures is specifically attributable to the aggregate population growth over that period of time.

An additional reason for increased health care expenditures is the aging of our population. Health care expenditures and the federal responsibility for health care coverage through Medicare will increase over time as the population and elderly population in particular increases. Between 1983 and 2025, the total population is projected to grow by almost 30 percent, with the elderly population doubling to a total of 58 million or 19.4 percent of the total population. Among the elderly, the group over age 75 will also experience substantial growth: 40 percent of the elderly are now older than age 75, and this figure will increase to 45 percent in 2025; and the over age 85 group will triple from the current 2.5 million people to 7.6 million in 2025.

Individuals over the age of 65 are more likely to be hospitalized than those under that age; they use more hospital days per hospitalization; and they visit their physician and other health care practitioners more frequently. The importance of these figures is clear: as the population ages, demands for health care services correspondingly increase and the total cost for providing those services increases.

A further factor that has contributed to the level of increase in health care costs is the liability crisis besetting the country. Physicians and patients alike pay for the rising cost of professional liability. So does the federal government as a major "purchaser" of health care services. Average premiums paid for professional liability insurance by self-employed physicians have risen from $5,800 in 1982 to $12,800 in 1986. Yearly increases well over 20% on the average continue to be documented. Premiums for high-risk specialists in Florida, New York, Illinois and other locations have soared to over $100,000 per year and are approaching $200,000 annually for some specialists in some locations.

The increase in premiums has been the leading factor contributing to the growth in patient medical bills in recent years. No other aspect of physicians' practice expenses has risen as quickly. Looking only at the total aggregate annual costs of professional liability coverage for physicians, $15.4 billion was spent in 1985. If passed along in large part to patients and taxpayers, this represents about 18.7% of the total expenditures for physicians' services in 1985.

Furthermore, the AMA recognizes that one element of consideration in examining health care services should be their cost-effectiveness. We are continuing to take positive actions to review the delivery of health care services and to work for the elimination of those health care costs that are inappropriate and are not benefiting the public.

THE FUTURE FOR PHYSICIAN REIMBURSEMENT

The AMA believes that the price or charge for a service is a matter between the physician and the patient. We believe that in America individuals should be able to get care through a pluralistic system, and that no single payment or delivery method should be advocated at the expense of another. The very choice offered in health care plans in this country, largely differentiated by payment methodology, is one of the strengths of our national economic structure.

We are proud to be at the forefront of the process to consider changes in Medicare's payment method for physician services. Discussions of physician reimbursement issues are appropriate, and there is a need to address inequities that have built up over several decades. These matters, however, must be carefully considered to avoid counterproductive results that could stem from unconsidered actions. Given the millions and millions of people who will be affected by any changes in the structure for how Medicare pays for physicians' services, we strongly recommend that where changes are made they be accomplished in an evolutionary manner.

A Resource-Based RVS: The Basis for Indemnity Payment Schedules

Change in fee-for-service methodology for setting physician payment should be based on a rational and comprehensive analysis of the resources that a physician brings to bear when he or she provides a medical service. For this reason, the AMA is actively involved with Harvard University in the development of a resource-based relative value scale (RVS). We believe that a schedule of indemnity payments based on such an RVS may provide a better basis for a more acceptable reimbursement system than would alternative proposals, such as physician DRGs, wide-spread capitation, or fragmented revisions, such as the Medicare program's "inherent reasonableness" proposals, freezes in payment, and maximum allowable actual charges.

The development of a resource-based RVS, scheduled for completion by July 14, 1988, is not a simple undertaking. This thirty-month endeavor has been based on substantial physician involvement through the use of scientific surveys of physicians and review by panels of physician experts. It is our expectation that the resource analysis approach taken by this study will prove to be the most appropriate basis for the construction of an RVS.

An extremely promising use of such a resource-based RVS is in an indemnity payment system. Under an indemnity fee schedule, the insurance payment amount would be known in advance to both physicians and patients, and they can agree upon further financial liability, if any.

Price Controls are not the Answer

In examining means to set payment levels for physician services, some have proposed fee controls. Price controls would have a serious negative impact. A recent statement on this issue endorsed by a group of highly respected leaders in economics, including two Nobel laureates, concludes:

> It is important to explore the sources of the price increases experienced by medical services because only after the causes are understood can a rational policy for the containment of the effects of those price increases be formulated. Moreover, to the extent that the price increases are to be attributed to real and largely unavoidable cost increases, rather than to the imperfect competitiveness of the medical care industry, the perils of the price control approach are necessarily exacerbated. If rising prices merely reflect real and unavoidable cost increases, a ceiling in prices will inevitably serve, in the long run, to curtail the supply of medical services in general; and a ceiling on fees for the treatment of the elderly is sure to reduce the quality and quantity of services supplied to this population group. Experience shows that, in the long run, it may even increase the prices this group is required to pay. In sum, such controls under these circumstances would constitute no benefit to the group of persons they are intended to protect. (A copy of this paper is attached.)

Payment Based on Diagnosis Related Groups (DRGs)

The AMA is unalterably opposed to a DRG-based physician payment plan. As the DRG payment for physician services would be based on an "average" for the mythically "average" patient, it would increase the present hospital-driven economic pressures for withholding care.

- Incentives caused by hospital DRGs already have limited the availability of services, as evidenced by nursing and other services pared by hospitals. Physician DRGs would create new incentives to limit access to physician services.

- By basing payment for both physicians and hospitals on DRGs, all of the economic incentives would be weighted against the patient, i.e. by providing fewer services, the hospital stay becomes more "profitable."

- DRGs do not pay for services actually rendered; in fact, they reward for services not performed. If extended to physicians, this mechanism would reinforce existing hospital incentives to reduce available care and avoid severely ill patients.

- Access to care in rural areas would suffer. Physicians would be discouraged from providing services in areas distant from their primary site of practice. Many rural hospitals already have experienced hardships due to the DRG payment methodology. It would be dangerous to further expand the DRG payment to services provided in hospitals already in crisis.

- The physician is the patient advocate, the one who now assures the patient that the DRG system does not affect patient needs. Extending the DRG to include physician payments would provide financial incentives that would erode the role of the physician as patient advocate.

Finally, House Concurrent Resolution 30 and Senate Concurrent Resolutions 15 and 56 have widespread bi-partisan co-sponsorship--326 House cosponsors on H.Con. Res 30, 48 Senate cosponsors on S.Con. Res 15, and 8 Senate cosponsors on S.Con. Res 56. They clearly state that it is neither feasible nor desirable to implement any method of payment for physician services based on DRGs.

Capitation

Our society should maintain a pluralistic system for setting the manner in which physicians receive reimbursement for the services they provide. Just as today, physicians and patients should continue to have the opportunity of participating in a variety of practice and payment methods. Alternatives must be closely examined before being imposed on the population.

Capitation, as exemplified by the current array of health maintenance organizations and competitive medical plans, has its place in the health care marketplace. However, to be effective, capitated systems should only operate in areas where they are part of a competitive environment and individuals have free choice among numerous health care plans. Our population should not be placed in a position where their only choice of a physician is one who takes part in a capitated payment methodology.

Specialty Differentials

In examining specialty differentials in setting payment, there are two key factors that must be considered: whether there should be a differential for services provided by physicians of different specialties; and delineation of physician specialty. The American Medical Association believes that this issue should be addressed as an element in a larger analysis of physician reimbursement under Medicare.

Under the current Medicare payment concept, the AMA believes that specialty differentials and payment levels should reflect differences in charging patterns among specialists. The AMA believes it would be premature to revise the current system in which Medicare carriers have the authority to differentiate payments for a service based on the specialty of the physician providing the service. Restructuring how carriers handle specialty differentials in isolation from a comprehensive review of the Medicare physician payment system would be just a continuation of the piecemeal changes that unfortunately have characterized the Medicare program in recent years.

The American Medical Association is midway through the process of reviewing physician reimbursement under Medicare, and the question of specialty differential is an element of this review. The Physician Payment Review Commission, which also is in the middle of such a review, similarly has indicated in its March 1988 Report to Congress that it is "not ready to recommend a specific (specialty differential) policy."

On the issue of designating how an individual qualifies as a specialist, the AMA believes that a variety of criteria are valid. The existence or lack of board certification should not be a sole determinant for ascertaining whether someone qualifies as a specialist. The bottom line is the competence of the individual physician to provide the services normally associated with a specialty practice.

Beneficiary Cost-Sharing

The request from the Committee for this statement also discusses "the effort to control beneficiary cost-sharing." With the large number of Medicare claims taken on an assigned basis, the fact that rigid fee controls through the maximum allowable actual charge (MAAC) program are already in place to limit beneficiary cost-sharing, and the pending legislation to impose "catastrophic" limits, the AMA believes that there is no need for any further efforts to control beneficiary cost-sharing.

Throughout the nation, concerns are being expressed that Medicare beneficiaries are in need of protection from the charges of physicians under Medicare. A common response has been to propose that all physicians be mandated to accept assignment of all Medicare claims. States are increasingly proposing that physicians be mandated to accept all Medicare claims, something the U.S. Congress has rejected. Mandated assignment, in addition to being counterproductive and ultimately harmful to beneficiaries, is not necessary. Physicians have an excellent record of accepting assignment, and voluntary assignment programs are being established by state medical societies.

The AMA has assisted medical societies across the country in launching programs to assist low-income Medicare beneficiaries by helping them locate physicians who will accept assignment on their claims. Each program is designed to meet specific local needs and circumstances by building upon the most appropriate infrastructure within a community.

The AMA has strongly encouraged physicians to accept Medicare's approved amount as full payment for those Medicare beneficiaries for whom additional payment would be a hardship, and response of the physicians to the Association's call has been excellent. Overall claims accepted on an assigned basis have increased from 52.8% in 1982 to 74.6% in the last quarter of 1987. The data also show that the rate of assignment increases as the patient ages, as the cost of a service increases, and as total out of pocket expenses increase.

Given the excellent track record of physicians in accepting assignment and the fact that assignment is routinely accepted for patients in financial need, the AMA believes it is unnecessary to require assignment to be accepted for all beneficiaries, especially without regard to their income level. A stereotype that must be addressed is one relating to Medicare beneficiaries themselves, namely, that all of the elderly were poor and in need of assistance. While we do not deny the reality of poor elderly, the facts point out that in 1985 only 12.1% of the elderly were below the poverty line, compared with 14% of the rest of the population.

Voluntary assignment programs of the state medical societies and the high rate of assigned claims have given needy beneficiaries continued access to the full range of Medicare-covered services. The medical profession is meeting its responsibility in providing care to America's elderly.

LOOKING TO THE FUTURE

The American Medical Association recognizes that the status quo of today will not and should not be the norm for the future. The need for a reform of the Medicare program cannot be underscored enough. For many years the AMA has recognized that the Medicare program is fraught with problems. The most telling symptom of these problems is that the program is headed toward fiscal insolvency shortly after the turn of the century. This fact, coupled with the virtually relentless tinkering with the program that we have seen during this decade based on fiscal concerns, acted as a catalyst for initiating an in-depth review of the Medicare program. This review culminated in a proposal to reform financing health care for the elderly. This proposal has been introduced by Representative Charlie Rose (D-NC) as H.R. 4455.

Key elements in our proposal include pre-funding health care for the elderly and the assurance of adequate funding. To accomplish this, the proposal calls for contributions to be made during working years in an amount sufficient to fund future health care costs for those now working, and at the same time, pay present health care costs for those now on Medicare. The program would cover the entire elderly population in the United States. To achieve the funds necessary to prefund the program, we recognize that taxing authority would have to be exercised in a manner to assure the collection and maintenance of adequate funds so that each individual upon attaining eligibility would be provided a voucher to purchase a private health insurance plan that would cover a comprehensive level of benefits.

Under our proposal, tax rates would be set at a level sufficient to pay the cost of vouchers for all eligible persons in the program in the first year of operation and each year thereafter. The tax rate would be sufficient to assure true prefunding of the program with future tax contributions made and preserved for those who contribute them. These tax dollars will earn interest and other investment income during the contributing years rather than being paid out immediately for beneficiaries then on the program.

Health Care Coverage

Under the proposal, all individuals who reach eligibility age will be entitled to an annual voucher that will be sufficient to purchase a policy providing the required comprehensive level of benefits. The benefits would be a more comprehensive benefit package than is currently provided under the Medicare program.

Through the use of their vouchers, beneficiaries would be able to choose insurance plans offered from Blue Cross/Blue Shield plans, commercial companies, HMOs, and other health benefit plans where the policy offered provided at least the specified adequate benefits. Importantly, the policy would have to provide a limit on out-of-pocket spending or cost-sharing for covered services of $2,500 per individual, $3,750 per family for most enrollees.

Needs Testing and Additional Savings

In recognition of the fact that many elderly individuals are relatively well off, the proposal calls for the amount of cost-sharing for covered services to vary based on the beneficiary's adjusted gross income.

Some individuals may want to set aside funds to purchase even more comprehensive policies and to provide coverage for the purchase of Medigap insurance and to cover deductible expenses. The proposal has provisions to authorize individuals to use the individual retirement account mechanism to meet these needs. Under the program, all working individuals will be allowed to contribute a before-tax amount of $500 a year to an IRA. After attaining eligibility age (or on becoming permanently disabled), all IRA withdrawals for health expenses would be tax free. We believe that the use of the IRA savings mechanism would provide a valuable supplemental source of health care funding for individuals under the new program. Also, these funds could be used for the purchase of needed long-term care services and further health insurance.

THE HEALTH CARE SECTOR AS PART OF THE NATIONAL ECONOMY

The health care sector has become one of the largest components of the American economy. The provision of health care services is directly responsible for 5.7 million full time jobs and ranks second among the nation's industries behind retail trade. Hospitals and other providers of health care services are major sources of jobs and income for their local economies. Each office-based physician employs an average of 2.1 full-time equivalent non-physician personnel. Health care is highly labor intensive and from 1984 to 1986 showed a 2% increase in total private employment and a 3% increase in work hours.

The cost of this large labor pool is more frequently discussed in terms of total spending for health care services. In 1986, this amounted to $458.2 billion, with hospital care accounting for 39.2% and physicians services accounting for 20.1% of the total expenditures. The balance of the expenditures were as follows: nursing home care - 8.3%; drugs - 6.7%; dentists services - 6.5%; research and construction - 3.6%; program administration and insurance - 5.4%; other professional services - 3.1%; eyeglasses and other appliances - 1.8%; government public health activities - 2.9%; and other personal health care - 2.6%.

Government and employers of all sizes are also becoming more concerned with achieving economies in health care payment and delivery systems, as their increasingly costly commitment to provide health benefits coverage may conflict with the budget and competitive pressures that they face. It is unfortunate that the cost of meeting health care needs is often viewed today as budgetary or competitive problems instead of in human terms. Cost concerns in both the public and private sector seem to be becoming the paramount issue in the debate over the future of health care.

CONCLUSION

The AMA believes that the great advances in the American people's health status has occurred because this country has devoted necessary resources to the health care sector and has not created a single system of health care. We believe this policy should continue. We also believe that great strides can be made by encouraging the American public to prevent illness through adoption of healthier lifestyles such as improved diets, reduced smoking and exercise. The federal government can play a valuable role in encouraging such activity.

America's physicians will continue to cooperate in our nation's continuing commitment to assure the highest possible level of quality health care to all Americans. While expenditures for health care have greatly increased over the past 30 years, the nation and its economy as a whole have received significant benefits from these expenditures. These benefits relate to improved health status, longer life expectancy, and improved quality of life. Productivity also increases when absenteeism from illness is reduced and when chronic conditions can be controlled with workers continuing in their jobs.

3806p

PRICE CONTROLS—AN INAPPROPRIATE PRESCRIPTION FOR THE RISING COST OF MEDICAL CARE

Elizabeth E. Bailey
Dean, Graduate School of Industrial Administration
Carnegie-Mellon University

William J. Baumol
Joseph Douglas Green, 1895, Professor of Economics
Princeton University
and
Professor of Economics
New York University

James M. Buchanan
Nobel Laureate in Economics
Harris University Professor and General Director
Center for Study of Public Choice
George Mason University

Carl F. Christ
Abram G. Hutzler Professor of Political Economy
Johns Hopkins University

H. E. Frech, III
Professor of Economics
University of California at Santa Barbara

Lawrence R. Klein
Nobel Laureate in Economics
Benjamin Franklin Professor of Economics and Finance
University of Pennsylvania

Marc L. Nerlove
Professor of Economics
University of Pennsylvania

Sam Peltzman
Professor of Economics and Finance
Graduate School of Business
University of Chicago

James B. Ramsey
Professor of Economics
New York University

Richard L. Schmalensee
Professor of Management and Economics
Massachusetts Institute of Technology

Martin Shubik
Seymour H. Knox Professor of Mathematical Institutional Economics
Yale University

Sir Alan Walters
Professor of Economics
Johns Hopkins University

March 11, 1988

PRICE CONTROLS—AN INAPPROPRIATE PRESCRIPTION FOR THE RISING COST OF MEDICAL CARE

During the last several decades, the costs of medical services have been rising at a rate persistently more rapid than that of the general price level. This constitutes a real and very urgent problem for the poor in general, and for the elderly poor in particular. But it is a problem which cannot be solved by legislation which seeks to declare its symptoms illegal. Recent proposals undertaking to impose ceilings on the fees that doctors would be permitted to charge their Medicare patients amount to the imposition of a system of price controls. As with most price control measures, these proposals are not only likely to fail to achieve their objective, but are apt to impose a costly burden upon the very persons whose interests they would attempt to protect.

In common with many other personal services, such as education, the performing arts, and a variety of services performed by state and local governments, the costs and prices of medical services have indeed risen at rates substantially higher than the economy's overall rate of inflation. During the 40-year period since 1947, according to U.S. government statistics, in constant dollars, the price of a visit to a doctor's office has risen some 150 percent, the cost of elementary education per pupil per day has risen about 300 percent, and the cost of a day of hospital care has increased approximately 1,750 percent.

No one is sure of the full explanation of these very substantial increases in the cost of medical services. But the rising physician-population ratio, the rising proportion of applicants accepted by medical schools, the increase in the number and membership of organizations such as HMOs (Health Maintenance Organizations) and PPOs (Preferred Provider Organizations) whose objective is to hold down medical care costs, and the fact that (in constant dollars) physician incomes have been virtually constant for more than a decade, all suggest that there has been no decline in competitiveness in the health care area such as would account for the pattern of sharp increase in the relative prices of medical services. There is good reason to conclude, rather, that a substantial role was played by the fact that medical care is a personal service which is not amenable to the rates of productivity increase which, for example, have constrained the rates of price increases of manufactured products.

It is important to explore the sources of the price increases experienced by medical services because only after the causes are understood can a rational policy for the containment of the effects of those price increases be formulated. Moreover, to the extent that the price increases are to be attributed to real and largely unavoidable cost increases, rather than to the imperfect competitiveness of the medical care industry, the perils of the price control approach are necessarily exacerbated. If rising prices merely reflect real and unavoidable cost increases, a

ceiling in prices will inevitably serve, in the long run, to curtail the supply of medical services in general; and a ceiling on fees for the treatment of the elderly is sure to reduce the quality and quantity of services supplied to this population group. Experience shows that, in the long run, it may even increase the prices this group is required to pay. In sum, such controls under these circumstances would constitute no benefit to the group of persons they are intended to protect.

We strongly urge that price controls for medical services not be adopted precipitously. We believe that careful consideration of the matter will make it clear that price control measures for medical services are to be avoided altogether, and that a serious social problem such as this one merits a more reasoned and more promising approach.

Elizabeth E. Bailey
William J. Baumol
James M. Buchanan
Carl F. Christ
H. E. Frech, III
Lawrence R. Klein
Marc L. Nerlove
Sam Peltzman
James B. Ramsey
Richard L. Schmalensee
Martin Shubik
Alan Walters

Item 11

STATEMENT TO THE SENATE SPECIAL
COMMITTEE ON AGING

PHYSICIAN PAYMENT

BY THE AMERICAN OSTEOPATHIC ASSOCIATION
June 1, 1988

American Osteopathic Association (AOA) appreciates this opportunity to comment on the reform of Medicare's system of payment for physician services. The Senate Special Committee on Aging is to be commended for its leadership in providing a forum for a variety of viewpoints on issues of serious concern to patients and physicians.

Osteopathic physicians provide complete medical care to patients of all ages. Their services have been recognized by Medicare since the program's inception, both through reimbursement to the patient and support of graduate medical education programs in osteopathic hospitals.

The Committee is rightfully concerned about the amount of money beneficiaries must bear above that which is paid by Medicare. The AOA shares this concern. It is appropriate to call for a discussion of this issue in tandem with the need to provide fair reimbursement for physician services.

The existing payment mechanism for physician services under Medicare is complex and difficult to fathom for patients and physicians, alike. In addition, it is nearly universally acknowledged to be flawed in such a way as to perpetuate its built in inequities. Congress recognized these problems when it created the Physician Payment Review Commission in 1985. The short and long-term solutions recommended by the Commission to date have the overall support of the AOA. We believe that the most recent annual report to Congress lays the groundwork for the serious and thoughtful debate on payment reform that must occur.

The AOA believes that the problems caused by the "customary, prevailing and reasonable (CPR)" payment mechanism can and must be addressed within the context of preserving the fee-for-service system. Worthwhile short-term steps have been taken by Congress to offset some of the more negative effects of the CPR system. These steps include the provision of payment adjustments for primary care services, as well as the rural care "bonus" to go into effect in 1989.

These actions serve the dual purpose of encouraging the provision of care where it is most needed, while lessening the bias of the existing system toward costly procedures at the expense of the physician's cognitive skills. The work of the Harvard resource-based relative value scale study also should provide a means to address this major inequity.

The osteopathic profession believes that pluralism in health care, that is, the availability of a range of options for patient care, has served the American public well. The ability of patients to choose whomever they wish as their physicians must not be compromised. The AOA strongly believes that the reforms that lie ahead for Medicare must also preserve the patient's freedom of choice.

It is understandable that federal health policymakers are concerned about the amount of money patients pay above and beyond their Medicare benefits. This has long been a concern of physicians, as well. The AOA does not believe mandatory assignment is the proper way to address the problem. Our belief is founded on physician behavior as documented by the Health Care Financing Administration (HCFA). Recent statistics presented to Congress by HCFA indicated that more than 70 percent of Medicare claims, on a dollar volume basis, were handled on assignment. This is true even though less than 30 percent of physicians are "participating physicians," and despite the fact that the existing payment system often is unfair.

The AOA believes this evidence shows that physicians, when free to decide financial arrangements with their patients, will most often do so in a compassionate and fair manner. In those few cases where a physician refuses assignment regardless of the patient's circumstances, the patient retains the freedom to select a new physician. The AOA believes that the overwhelming majority of physicians make assignment decisions based on the needs of their patients. The fact that this is the case today makes it likely that even greater acceptance of assignment would occur under a more equitable reimbursement system.

On another issue, the Committee has sought comment on the possible elimination of the Medicare payment differentials based on specialty practices. In general, the AOA supports this concept. It must be realized, however, that it is often very difficult to determine whether a given service is equal from provider to provider. This is true even of services coded identically by physicians. AOA believes that clarification must occur if "equal pay for equal service" is to succeed.

Also at issue in this debate is the definition of a specialist. AOA believes that specialty is determined by one of three factors: board certification; board eligibility; or recognition by a peer group of a physician's skill in a given area (i.e., hospital privileges). The current practice of some Medicare carriers to accept the physician's self-designation of specialty is no longer appropriate.

It also must be pointed out that the April 12, 1988 Federal Register notice concerning this subject contained an error with regard to certification of osteopathic specialists. The individual osteopathic specialty boards provide such recognition with the consent of the AOA Board of Trustees.

The AOA recognizes the complexity of the issues the Committee seeks to resolve. Congress has acted responsibly in its determination to reform Medicare payment for physicians. We appreciate your understanding of the need to balance Federal budgetary goals with the equally important necessity to maintain access to high quality medical care. The members of the American Osteopathic Association are committed to bearing their share of the burden in preserving our health care system. We believe that working together, Congress and the health care community can make the system more cost effective while maintaining quality. We welcome the opportunity to participate with you in this process.

Item 12

American
Psychiatric
Association

1400 K Street, N.W.
Washington, D.C. 20005
Telephone: (202) 682-6000

June 2, 1988

The Honorable John Melcher
Chairman, Special Committee on Aging
U.S. Senate
Dirksen G-41
Washington, D.C. 20510-6400

Dear Senator Melcher:

Thank you for your recent letter asking for the American Psychiatric Association's views and recommendations regarding possible physician payment reform options. The American Psychiatric Association, a medical specialty society representing more than 34,000 psychiatrists nationwide, appreciates that the Congress' debate on Physician Payment Reform under Medicare will be a complex one, but urges that the linchpin of this debate should be the critical need to protect quality medical care at the same time that we address new methods of paying physicians. Quality care cannot always save money in the short run, but initial treatments may prove cost-effective in the long-run.

Psychiatry, through its members of the Technical Consulting Panel, is participating in the Harvard Resource-based Relative Value Scale Study. Because this study is not scheduled to be released to HCFA until July 14, 1988, APA feels the notice published by the Health Care Financing Administration in the April 12 Federal Register is premature. Rather, we suggest HCFA should await the results of the Harvard study before requesting communications from the various affected parties and preemptorily judging the study.

Prior to commenting on certain aspects of the Physician Payment Review Commission's report, I would like to take this opportunity to briefly share with you our estimates of the elderly population in need of intervention as well as data about treatment by psychiatric physicians. As you know, the Congress began a legislative journey to respond to Medicare's discriminatory outdated and outmoded outpatient benefit for treatment of patients with "mental, psychoneurotic and personality disorders" in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203). The Congress' action was recognition of the explosion of knowledge in the field of psychiatry in understanding the physiological bases and concommitants of mental disorders and potential cost-effective treatments.

As the elderly population grows and ages, patients with multiple comorbidities will need treatment by more than one health provider. Estimates indicate that some 15 to 20 percent—between 3 and 5 million—of our nation's more than 25 million older persons have significant mental health problems, yet they have been denied adequate treatment in the past because of discriminatory coverage limits (even the major and significant changes made by OBRA '87 maintain a distinction between physical and mental disorders). Statistical estimates also indicate that twenty to thirty percent of older Americans who have been labeled "senile" have treatable, reversible conditions which, if appropriately managed, could allow our elderly citizens to become more active, productive members of society. Recent changes in the Medicare benefit may assist our elderly patients to take advantage both in economic and human terms of breakthroughs in the neurosciences.

Through recent research, the genetic basis for manic depression has been identified; we have attained the capacity to treat more than 85% of all severe depressions using drugs and psychotherapies; we have verified the existence of a genetic component to psychoses; and determined that environmental factors may trigger one's inherited predisposition to a mental disorder; and through techniques such as positron emission tomography and nuclear magnetic resonance, we have gained a capacity to observe biochemical activity in the conscious brain and define discrete areas of the brain that may be defective in certain illnesses. Finally, we have developed pharmacologic and behavioral treatments that are effective in treating phobias and other anxiety disorders and demonstrated that memory loss and other cognitive defects associated with Alzheimer's disease may be modifiable with medication. There is also evidence to indicate that having a psychiatric diagnosis is associated with a high risk of medical illness, and that there are a great many physical disorders that upon initial presentation appear to be nervous and mental disorders.

The research literature fully documents psychiatric illness produced by infections, thyroid gland dysfunction, chronic encephalopathy related to heart block, carcinoma of the pancreas and other disorders. These studies also emphasize the importance of the interrelationship betwen specific psychiatric symptoms and specific medical disease. Interestingly, America's killer disease AIDS may initially present with memory disorder and depression.

Data from recent years indicates that despite the many mental health needs of the elderly population, our older Americans receive only 6 percent of community mental health services and 2 percent of private psychiatric services.

Early 1980 estimates indicate that 8 percent of psychiatrists patients are Medicare patients. Many Medicare beneficiaries were reaching their $250 annual limit (prior to the benefit change in OBRA '87). Between 1975 and 1986 the number of Medicare beneficiaries who had used outpatient psychiatric services increased almost eight-fold from just over 8,000 beneficiaries to over 60,000 beneficiaries or from .7% of all Medicare beneficiaries to 1.85% of all Medicare beneficiaries. At the same time, the number of beneficiaries reaching their maximum outpatient limitation increased from 4.95% of users of mental health services (or .03 % of the Medicare population) to 11.2 % of users of mental health services (or .21 % of the Medicare population). Although the number of Medicare beneficiaries using psychiatric services may be small relative to the Medicare population as a whole, evidence exists that poor coverage may have discouraged them from using the services.

In 1985, psychiatrists treating Medicare patients received on average approximately 65% of their billed charge (as a ratio of billed to approved charge). During the first year of the Medicare participating physician program, about 3% of psychiatrists elected to become participating practices. By January 1987, the number of participating practices was 28.6%. In 1985, 68.5% of all Medicare Part B claims were accepted by all physicians on assignment, and 75% of psychiatry claims were accepted on assignment. One study of selected states noted that psychiatrists accepted claims on assignment among the highest of any physicians.

PHYSICIAN PAYMENT REVIEW COMMISSION REPORT

APA has reviewed the findings of the Physician Payment Review Commission report and will comment briefly on selected areas. First, as mentioned above APA is participating in the Harvard resource-based relative value study and it appears this study may result in identifying more accurately than curent methods of payments the components of psychiatric practice. Second, psychiatry is unique in the limited number of codes that are available to this medical specialty through CPT and at times accepted by the carriers. Psychiatric practice has changed substantially in the past twenty years, and services may be too bundled for appropriate billing. Third, APA is pleased that the PPRC will address methods of updating the fee schedule chosen. Fourth, as mentioned above, despite depressed reimbursement, psychiatrists have accepted Medicare patients' bills on assignment at a higher than average rate and the option of choosing which bills to accept on assignment would be a helpful one to maintain. Fifth, as the Congress debates methods of monitoring utilization, please know that APA has been a leader in the field of quality assurance and peer review activities and we are at the moment as far as we know, the only specialty which has its own peer review program—one which has worked with CHAMPUS and private insurers since the late 1970's and has saved or reduced the growth of expenditures substantially. Our association has examined, through its peer review mechanisms, issues comparable to practice guidelines. While these guidelines may be important as a baseline for measuring utilization, the interpretation of overutilization may be made by someone not skilled in understanding the innuendos of medical intervention and at times unnecessary denials may occur when such guidelines are employed. Sixth, we are pleased that the PPRC will examine issues related to inapropriate service delivery in HMO's including underservice. We would hope that the PPRC would also examine the issue of internal exclusion of the chronically ill, in particular, the chronically mentally ill patients, in HMOs.

As the Special Committee examines future issues related to physician payment, please know of our interest and support in working to address the concerns of persons with mental disorders, particularly in our vulnerable elderly patients.

Sincerely,

Jay B. Cutler
Special Counsel and Director
Division of Government Relations

ESS/JBC/wyg

Item 13

ASIM TODAY

STATEMENT OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE

SENATE SPECIAL COMMITTEE ON AGING

ON PHYSICIAN PAYMENT

JUNE 1, 1988

asim
american society of internal medicine
1101 VERMONT AVENUE NW • SUITE 500
WASHINGTON, DC 20005-3457 • (202) 289-1700

STATEMENT OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE

SENATE SPECIAL COMMITTEE ON AGING

ON PHYSICIAN PAYMENT

JUNE 1, 1988

Introduction

The American Society of Internal Medicine (ASIM) appreciates the opportunity to express the views of internists throughout the country on alternative payment methods for physician services under the Medicare program.

In the years since ASIM was founded in 1956, the Society has played a leading role within the medical profession in studying and formulating innovative approaches to paying for physician services. During the past eight years in particular, the Society has devoted considerable time and resources to identify the problems in the current system of payment for physician services--and developing constructive proposals to address and resolve those problems. In this process, ASIM has developed specific objectives and principles on payment for physician services that can serve as a basis for legislation to alter the current system of payment under the Medicare program.

Congress has demonstrated its support for efforts to enhance payment for traditionally undervalued primary care services, most recently through passage of legislation that increased Medicare payments selectively for primary-care services to a greater degree than all others. Congress also recognized the important contribution of the results of the Harvard resource based relative scale, now under development, to physician payment reform, by including in the Omnibus Budget Reconciliation Act (OBRA) of 1986 provisions that delay until January 1989 the requirement that the Secretary develop a relative value scale as a basis for payment under Medicare (thus allowing for completion of the Harvard project.) Moreover, in OBRA 1987 Congress required the Department of Health and Human Services to submit by July 1989 a study of changes in the payment system for physicians' services that will be required for the implementation of a national fee schedule by January 1990. Similarly, the Physician Payment Review Commission, charged with the important task of recommending changes in Medicare's system of paying physicians, has for the second consecutive year endorsed measures to improve payments for undervalued cognitive or primary care services.

This statement will focus primarily on ASIM's response to the recommendations on physician payment contained in the Physician Payment Review Commission's (PPRC) second annual report to Congress.

Report of the Physician Payment Review Commission

ASIM believes that the recommendations and analysis contained in the Commission's second report to Congress deserve serious consideration. The Commission has done an admirable job of translating the goals for physician payment policy it identified in its first report to Congress, into viable options for short-and-long-term reform. While much remains to be accomplished in the coming year, the Commission is well on the way to achieving rational solutions to the problems facing the physician payment system under Medicare. ASIM generally supports the direction the Commission is taking and has the following specific comments on areas addressed in the report.

Fee Schedules

ASIM strongly supports the Commission's recommendation that a national Medicare fee schedule be established based primarily on resource costs. In endorsing a resource-cost relative value scale, the Commission specifically rejected an RVS based on historical charges, arguing that "the current pattern of relative charges is likely to be distorted" and noting that "the desire to depart from current patterns of relative values is the principal reason" for its endorsement of a resource-based RVS. ASIM agrees with the Commission's analysis of why historical charging patterns have been distorted by the health insurance market:

> "Historically, [insurance] has covered surgery more extensively than medical services. In some plans, surgery is the only physician service covered. The use of deductibles has contributed to this orientation because a higher proportion of small bills (mostly for primary care) are not reimbursed. A patient seeking primary care knows that in many instances the entire bill will have to be paid out-of-pocket, while a patient seeking surgery expects that insurance will pay most of the bill. As a result, patients tend to be more sensitive to the price of primary care than of surgery, and this affects relative prices. While Medicare's coverage of physicians' services is less uneven than that of many private plans, the charges that are the basis of its CPR payment are affected by the overall pattern of insurance coverage."

For years, ASIM has argued for the development and implementation of a resource cost based schedule of allowances as a basis of payment under Medicare. Such a system would correct the historical distortions cited by the Commission in its report. By developing a relative value scale based on resource costs--which in turn would be used to construct a schedule of allowances by the inclusion of appropriate dollar conversion factors--Medicare for the first time would have a relatively simple, understandable, and predictable system that would reduce the distortions in the relative values of cognitive and procedural services. A resource cost payment system--by placing more reward on time consuming, complex "cognitive services" in comparison to technical procedures--would be a major step toward reducing incentives for over utilization of high-cost technology, thus making fee-for-service under Medicare a far more cost effective payment option than is now the case.

ASIM is pleased that the Commission is giving prominent attention to the work of Professor Hsiao of Harvard University, and appreciates the need for the Commission to carefully evaluate the Harvard RVS. The ultimate credibility of that effort, ASIM believes, will be enhanced by an open and candid discussion of its merits. We believe

that the Commission can play a very useful role in promoting such discussion and specifically endorse the use of public hearings to receive comments on the project.

ASIM has some concerns, however, over the Commission's stated intention to consider other methods for estimating resource costs, including resurveying physicians and/or convening consensus panels to "address possible limitations in methodology." We have urged the Commission to exercise caution in allowing the Harvard results to be substantially revised through consensus panels, a process that is likely to be a less scientific approach to establishing relative values. As a consequence, a revised RVS based primarily on the work of consensus panels--which will be composed of far fewer physicians than participated in the Harvard study--is likely to be less acceptable to to physicians, beneficiaries, policymakers and others. Moreover, consensus panels must not become the vehicle by which individuals who are more interested in maintaining the status quo than achieving equity attempt to "refine" the study to the point where the "refinements" are so extensive that the RVS ends up echoing patterns in the existing charge-based system.

ASIM cautions Congress not to prejudge the Harvard project before the results are released based on claims by critics of the study that the methodology is unsound. Although it is proper to have an open discussion and constructive debate on the appropriateness of the Harvard methodology and its conclusions, such debate should not become a vehicle for delaying or blocking fundamental change in the payment system. Discussion should focus not only on narrow technical issues, but more appropriately on the broader philosophical issue of whether inequities in the Medicare physician payment system should be redressed by replacing Medicare CPR with a schedule of allowances based on resource costs.

Specialty Differentials

ASIM is aware of the Health Care Financing Administration's request for comments on whether to discontinue the establishment of separate prevailing charge screens for physicians' services based on specialty practice. We are in the process of reviewing the Federal Register announcement and will be happy to share our comments with the Committee when they are available.

Generally, our position at this time is that the issue of specialty differentials should be addressed in the overall context of the development of a resource-based relative value scale. PPRC in its report indicates that it will begin developing a uniform national policy for specialty differentials under a fee schedule. Therefore, ASIM believes that it would be premature for HCFA to make any changes in its current policy before it has the benefit of PPRC's analysis, which will involve consultation with outside groups and more indepth study than HCFA could devote. As PPRC notes, "...any change in policy for specialty differentials before implementation of a fee schedule would impose substantial administrative costs on carriers and physicians, and its effects on access, cost, and quality would be difficult to predict."

ASIM also believes that to the extent that the resource costs involved in providing a service differ according to the training of a physician, those differences should be recognized by placing an appropriate relative value on the specific service billed by that physician, rather than by specialty differentials for all services. This view is largely consistent with the Commission's approach which argues for improving definitions of existing codes or developing a new set of codes to account for differences in work by specialty, resorting to specialty differentials in payments only if coding reform turns out not to be a feasible solution.

Assignment and Participation: Policy Options

The Commission outlines various options to encourage improved acceptance of assignment--educating beneficiaries on the "advantages" of seeking out participating physicians, "all-or nothing assignment", limiting balance billing for selected services--but does not make specific recommendations. ASIM is concerned, however, that the strategies outlined by the Commission seem more directed to encouraging patients to select physicians who will accept assignment on all claims or making it far more difficult for physicians to decline to become participating physicians, rather than to improving the overall acceptance of assignment.

ASIM continues to believe that a more appropriate policy objective is to assure that those patients in financial need are appropriately taken care of (either through reduced fees or acceptance of assignment), rather than attempting to force physicians into accepting assignment for all patients. Improvements in the payment levels for various services (particularly for undervalued cognitive services), encouragement of voluntary programs by which physicians agree to accept assignment or reduce fees for those patients in need, improving Medicare billing procedures so that all physicians have a greater incentive to accept assignment, improving the dissemination of information on fees and assignment policies so that patients know in advance whether or not a physician will accept assignment and the difference (if any) that he or she may be responsible for paying out-of-pocket, and other strategies designed to target those patients most in need all merit consideration.

Unfortunately, most of the strategies outlined by the Commission fail to target those patients most in need or to provide sufficient flexibility for physicians and patients to negotiate payment arrangements that do not involve acceptance of Medicare assignment. While acceptance of assignment may appear to reduce beneficiary out-of-pocket expenses (which may not be necessarily true if the volume of services and the required copayment is increased as overall cost-sharing per service diminishes), it may do so at the price of reduced access to necessary services and a weakening of the doctor-patient relationship.

ASIM believes that the evidence clearly shows that physicians are willing to accept assignment or discount fees to Medicare's "approved amount" for patients in need. ASIM's own "Personal Care" program, under which enrolled physicians agree to several measures to improve the predictability of the Medicare assignment option (including publicizing the fact that they will accept assignment or reduce fees to Medicare's "approved amount" for all patients in financial need, issuing identification cards to specific patients that require special financial arrangements for an extended period of time, assisting in the filing of all claims for Medicare patients, and discussing fees and assignment policies in advance of rendering services) has received widespread acceptance within the medical community. Three state medical societies--the South Carolina Medical Association, the Colorado Medical Society, and the Medical Society of the District of Columbia--all have agreed to co-sponsor "Personal Care" in their own states. In just a few weeks, over 800 physicians have enrolled in "Personal Care" in South Carolina (representing almost 1/4 of all non-participating physicians in the states) and 500 have enrolled in the Colorado "Personal Care" program. All together, close to 2,000 physicians have joined the "Personal Care" program. Other state and specialty societies are exploring the possibility of co-sponsoring ASIM's "Personal Care" program for their own members, which should substantially increase overall enrollment. These and other voluntary programs to assist patients in financial need clearly demonstrate that physicians are willing to take appropriate action to help those patients who have difficulty affording their medical bills.

ASIM believes that Congress and the Commission should explore strategies that build upon this record, rather than promoting far more coercive (and disruptive) approaches to the balance billing issue.

Expenditure Targets

ASIM has serious concerns about the conclusions reached by the Commission on expenditure targets, namely that "expenditure targets are a potentially promising means of addressing the problem of rapidly rising volume of services." In its report, the Commission fails to address what ASIM considers to be the most significant disadvantage of this approach: the clear potential that expenditure targets will result in underprovision of needed services, thereby having a serious detrimental effect on the quality of medical care provided to Medicare patients. The most glaring example of this is in the United Kingdom, where subsidized care such as dialysis is denied for entire classes of people such as those over 55 years of age.

The basic problem with the expenditure target approach is that it imposes a predetermined decision on the amount of resources to be devoted to medical care on the ability of individual physicians to provide their patients with appropriate care. By placing all physicians at "risk" for services provided to their patients, a clear incentive exists for physicians to "do as little as possible" to stay within the expenditure target. Once an expenditure target is exceeded, payment levels over time would either be reduced immediately, or would be given little or no increase the following year. Once this occurs, it is quite conceivable that payment levels would be so constrained for many services that physicians would no longer be able to provide certain services to their patients. Both these effects could seriously diminish the quality of care provided to Medicare patients. It is ironic that given the growing Congressional concern over existing Medicare risk arrangements that may be adversely affecting patient care, the Commission now is looking favorably at placing all care provided to Medicare beneficiaries under a risk arrangement.

Second, since no one knows how to define an appropriate aggregate volume of services to be provided to beneficiaries, it is impossible at this time to even conceive of establishing an expenditure target that would be appropriate and realistic. Using adjusted per capita utilization at the U.S. average, for example, suggests that the "average" is the "appropriate" level of utilization, when in fact higher (or lower) than average utilization could represent the most appropriate care. Targets that involve restraints on the rate of increase, on the other hand, might constrain growth and services below what is appropriate for continued advancement in patient care. No matter how the initial expenditure targets are established, there is a clear danger that an administration or Congress that wishes to reduce federal expenditures on medical care would set expenditure targets that will save money—but at the price of reducing access to needed services.

Third, expenditure targets raise an equal protection issue. Beneficiaries who happen to live in a locality whose expenditure target has been exceeded may find that their access to care is subsequently reduced if physician find that they are no longer able to provide essential services at the lower payment levels, while patients in other areas that have not exceeded the cap may have access to more and (better) services.

Fourth, this concept grossly exaggerates the ability of physicians to control the practice patterns of their peers. Unlike an HMO or other contractual managed care system where physicians individually agree to abide by utilization controls as a condition of fulfilling their contractual obligations to the plan, there is no parallel mechanism for exerting influence across boundaries as large as a state. Indeed, antitrust statutes would be likely to preclude physicians from taking collective action to sanction a peer who is suspected of "overutilizing" services. Moreover, physicians who practice a prudent style of medical care would be penalized if their state exceeded the expenditure target to the same degree as physicians who are "overutilizers." This hardly creates a rational incentive for individual physicians to change their own practice patterns.

Fifth, unless the expenditure target applied to all payors, Medicare patients might ultimately find that they are discriminated against. Since Medicare patients would be the only ones whose care would be subject to an overall cap on expenditures, physicians may over time begin treating those patients differently (and not as well) as private patients.

For these reasons, ASIM urges Congress to proceed cautiously in evaluating the feasibility of expenditure targets for the Medicare program. Careful study of this approach and its implications for patient care must be undertaken before any quick conclusion is reached that this is a desirable way of controlling volume.

Increasing Appropriate Use of Services: Practice Guidelines and Feedback of Practice Patterns.

ASIM agrees with the Commission that "carefully developed [practice] guidelines can play a highly constructive role in the Medicare program." We concur that "both the process through which guidelines are developed and the ways they are applied must recognize the unavoidable uncertainty in medical knowledge and the essential role the attending physicians' clinical judgment must play in medical practice." This underscores the importance of assuring that medical organizations which have credibility with practicing physicians be involved in developing the guidelines. Physicians who are in day-to-day contact with patients, for example, may very well have a different perspective on treatment protocols than those physicians that are involved primarily in teaching.

ASIM supports the Commission's intent to convene a conference to develop a strategy to develop practice guidelines, and welcomes the opportunity to participate in this important project.

Improving Utilization Review in Medicare

ASIM supports the Commission's call for more intensive research and development efforts in the whole area of medical review. We believe that utilization review by Medicare carriers and peer review organizations can play an important role in reducing unnecessary volume of services provided that such review programs are implemented fairly and reasonably and in a manner that is the least intrusive as possible but is effective. As the Commission points out, "beneficiaries and providers frequently have problems getting prompt and understandable answers to questions and communications with physicians about local utilization review processes and problems are very limited."

The findings of ASIM's 1987 Carrier Accountability Monitoring Project (CAMP) survey bear this out. (Questionnaires for this survey were mailed to a representative sample of ASIM members throughout the country in July 1987. A systematic selection process was used to select every nth name from ASIM's membership files. The data in this survey are

based on the results of 763 completed questionnaires.) The survey results strongly suggest that there is a "crisis in confidence" in existing Medicare utilization review procedures. Fully 71 percent of ASIM members agreed with the statement "Medicare is requiring more unnecessary documentation for claims to be paid." Sixty-two percent agreed that "Medicare is increasingly rejecting claims for medically appropriate services to save money." And 65 percent rejected the notion that "Medicare is doing a better job at reviewing the medical necessity of claims and is rightfully rejecting more claims because they are unnecessary."

This crisis in confidence increases costs and greatly hinders the effectiveness of utilization review, by resulting in growing numbers of requests for "fair hearings" and reconsiderations (28 percent of all respondents indicated they had requested hearings for claim denials during the past year); an unwillingness among physicians to become involved in so-called "peer review," due to a perception that such review is inevitably skewed toward reducing costs at the expense of quality; antagonism between the Medicare program and physicians and beneficiaries who suffer when claims are inappropriately denied; and unnecessarily obtrusive and excessive requirements for documentation of services rendered to patients. If, on the other hand, physicians generally found utilization review processes to be valid and the utilization screens medically appropriate, there would be greater compliance with the Medicare standards, fewer denials, and fewer requests for reconsiderations and fair hearings.

ASIM believes that one place to start instilling more confidence in the medical review procedures is to require carriers to consult with physicians regularly in developing their review programs. Although the new HCFA proposal that all carriers employ a physician to serve at least half time as a medical director is a step in the right direction, it falls far short of any requirement that carriers consult regularly with representatives of practicing physicians in developing their medical review programs, or that they utilize peer review when there are questions concerning the appropriateness of a particular claim determination. ASIM recommends that Congress direct HCFA to strengthen its requirements relating to consultations with professional organizations on the development of medical review criteria. Congress should also require that HCFA direct carriers to hire a full-time medical director.

ASIM commends HCFA for requiring carriers to provide physicians an additional opportunity to show that services were in fact medically necessary, prior to a contrary finding by the Medicare carrier. As of April 1, carriers must request additional information from physicians prior to deciding a claim for lack of medical necessity. This requirement is only in effect on a trial basis, however. ASIM urges Congress to require HCFA to make this a permanent change, so that physicians continue to have the opportunity to present documentation to show when services provided were in fact medically necessary.

ASIM agrees with the Commission's recommendation that more funding be directed toward medical review. We believe, however, that increased funding should be contingent on the development of more effective utilization review procedures rather than simply increasing the level and intensity of current review by the carriers. One strategy is a targeted approach that would monitor overall physician practice patterns to identify practice "outliers" that appear to be aberrant in comparison to those of their colleagues. Once identified, services provided by those physicians could be scrutinized by peer groups in far greater detail to determine if, in fact, the care provided to individual patients was medically appropriate. This approach would likely receive support from the medical profession and be more cost effective in the long run.

Over the long term, ASIM also urges Congress to examine the utilization review criteria and methods used by the private sector for their potential applicability to the Medicare program.

Conclusion

In conclusion, ASIM urges Congress to carefully review the recommendations of the Physician Payment Review Commission and take appropriate action to facilitate those recommendations. The Society strongly believes the Commission's major recommendation, that a national Medicare fee schedule be established based primarily on resource costs, deserves particular consideration, and urges Congress to reaffirm its support for this approach. Once the RBRVS is developed, Medicare will have for the first time a rational system of payment that will reduce the historical inequities in payment for cognitive and procedural services.

ASIM welcomes the opportunity to work with the Committee in the future on this and other issues related to physician payment.

M-LA-1217b

Item 14

AMERICAN UROLOGICAL ASSOCIATION, INC.

OFFICE OF THE PRESIDENT
Joseph B. Dowd, M.D.
Lahey Clinic Medical Center
41 Burlington Mall Road
Burlington, Massachusetts 01805

June 1, 1988

The Honorable John Melcher
Chairman, Special Committee on Aging
United States Senate
Dirksen G-41
Washington, D.C. 20510-6400

Dear Chairman Melcher:

The American Urological Association is pleased to respond to your invitation to submit a statement for inclusion in the Committee's report on physician payment issues. The AUA has been deeply concerned by recent government actions affecting Medicare reimbursement for physicians' services and welcomes the opportunity to participate in the Committee's activities.

Our comments respond to your inquiries about the second annual report to Congress of the Physician Payment Review Commission (PPRC) and the April 12th Federal Register notice from the Health Care Financing Administration, as well as provide information on specific interests of urologists.

AUA is concerned that last year Congress reduced Medicare payment for transurethral section of the prostate (TURP) based on allegations that the surgery was "overpriced." TURP is the second most common surgical procedure under the Medicare program and is a natural consequence of the male aging process. Prostatic enlargement is extremely common in older men and, at the present time, there is no cure for this condition other than surgery. Untreated, this condition can lead to serious complications, including bladder and kidney damage. Congress, acting on advice from PPRC, reduced Medicare payment for this surgery. AUA expressed deep reservations about the work done to support this payment change, and in particular the methodology used. Our concerns were heightened by the results of an independent survey of urologists and by the preliminary results of research being conducted at Harvard University on relative values. Both analyses indicated that the judgment on the value of TURP was not correct

Economic changes such as this one, which have little basis in fact, ultimately harm Medicare beneficiaries. It is out of concern for urology patients, many of whom happen to be over 65, that we submit this statement.

Again, thank you for the opportunity to provide information on physician reimbursement issues to the Special Committee on Aging. Please feel free to contact AUA if you have any questions about this material.

Sincerely,

Joseph B. Dowd, M.D.

STATEMENT OF THE AMERICAN UROLOGICAL ASSOCIATION, INC.
TO THE SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
WASHINGTON, D.C.
June 1, 1988

The American Urological Association submits the following statement on behalf of its members and their patients to the Special Committee on Aging for inclusion in the Committee's report on physician payment issues. Medicare beneficiaries are important patients to urologists; therefore, we are deeply concerned about the program's future.

Part 1 - Omnibus Budget Reconciliation Act of 1987

In 1987, as part of the Omnibus Budget Reconciliation Act, Congress reduced Medicare payments for transurethral resection of the prostate (TURP). This operation, the second most common surgery under the Medicare program, is vital to an aging male population because prostatic enlargement is a common occurrence among older men. Left untreated, this condition can cause urinary retention, bladder damage, and ultimately kidney failure. Surgically treated on a timely basis, the patient can be free from these problems.

Congress acted on the basis of recommendations from the Physician Payment Review Commission (PPRC) which had identified nine surgical procedures it believed were "overvalued" by Medicare. The methodology for making this determination was derived in large part from work done in 1985 at Harvard by William Hsaio, Ph.D. for the Massachusetts Rate Setting Commission. These analyses of physician fees suggested that some surgical procedures, including TURP, were substantially overvalued compared to other medical and surgical procedures. However, the 1985 Hsaio study has been subject to significant criticism and limitations, not the least of which is an error rate which can approach 25 percent. Nonetheless, the PPRC was encouraged by Congress to proceed in this direction, largely because of the pressures of the federal budget deficit. The resulting recommendations, ultimately including 15 procedures, were adopted and cuts in payment went into effect on April 1, 1988.

From the beginning, AUA expressed serious doubts about the quality of the analysis that was being performed and the conclusions that were being drawn. In order to try to respond to these activities at PPRC and in Congress, AUA went to an outside consulting firm to conduct a survey of urologists about TURP and the current practices of urologists. To buttress this study, which focused on practice characteristics and socioeconomics, several urologists also conducted a retrospective review of 3800 TURPs in order to identify the current morbidity and mortality associated with that operation as well as to answer a number of other scientific questions.

The first study, conducted by Multinational Business Services, Inc. (MBS), addressed, in part, the issue of the relative value of this procedure compared to other medical and surgical procedures. Using the same base procedures used by PPRC in its analysis, a sample of over 2500 urologists, out of the 7744 queried, came up with answers on a variety of urological procedures significantly different from those achieved by PPRC or any prior analysis. The preliminary results of research currently underway at Harvard, under contract to the Health Care Financing Administration, confirms the results of the MBS survey. The second study, a scientific analysis which will be published later this year, dealt with a retrospective review of 3800 cases of TURP. As a benchmark, the researchers urologists used a 1960 study which had looked at 2500 TURP cases. Many interesting facts were learned through this second study including the facts that morbidity and mortality rates have declined substantially over 25 years, that the average age of patients (69) has remained

unchanged, and the average size of the gland removed (22 grams) has likewise remained unchanged. AUA believes these results are very important since the early study predates the Medicare program. One might reasonably suspect that the Medicare program could possibly have had some impact on the behavior of urologists. For example, might they be performing surgery earlier or on slightly younger Medicare beneficiaries in order to maximize their revenues? Clearly this is not the case since both the amount of tissue removed and the age of the patient are unchanged in a 25 year period.

When the article analyzing 3800 TURPs is published, AUA will be pleased to provide the Committee with copies.

AUA believes the results of these studies had some impact on the ultimate outcome of the legislative process. However, AUA remains deeply skeptical of the process by which these cuts in payment were derived and expresses the hope that neither PPRC nor Congress would ever again use so flawed an analytical system to make a judgement on the appropriate payment for any surgical or medical procedure.

One of the concerns often expressed by AUA during the debate over budget reconciliation last year was that these cuts, which we believe were arbitrary, could have a negative impact on either the quality or the availability of urologic care. TURP, according to the MBS survey, constitutes 38% of urologists' major surgery and 24% of their total patient workload. Thus, changes in payment have a significant impact on urologists and legitimate physician responses to these changes may affect beneficiaries. For example, older more experienced urologists (information gleaned from the surveys indicate that TURP is a difficult operation to learn and one that requires substantial operative experience to be performed at optimal level) may decide that the aggravation of dealing with the Medicare program is too much and they may choose to retire or to focus their practices on other activity. Only younger, less experienced surgeons will be performing TURPS.

Physicians may also be more reluctant to become participating physicians or to accept assignment because they feel that the reimbursement for an important part of their practice is disproportionately low under Medicare. As part of the MBS study, physicians were queried as to whether Medicare payment and private payment for the same surgery was similar. They uniformly responded that private payors tended to pay at least 20% more than Medicare for the identical effort. Further erosion of the Medicare payment can only lessen physician and beneficiary confidence in the program.

Physicians may also be less willing to settle in those parts of the country with traditionally low reimbursement, such as rural areas or small towns. Any one or more of these events could cause dislocations in the availability of high quality urologic care for Medicare beneficiaries. It would indeed be unfortunate if actions of the federal government limited the availability of urologic services at a time when, because of growing numbers of urologists, these specialized services are more widely available than ever before.

Of major concern to AUA is the fact that the Medicare program has continued to be a target for the budget cuts year after year. Even after all the cuts made in 1987, the Administration in 1988 recommended additional cuts in Medicare spending. While Congress wisely has chosen to reject these cuts this year, we realize that in 1989 budget pressures will be severe and Members may again look at the Medicare program for budget savings. This would be particularly anomalous in view of the fact that it seems quite likely that Congress will adopt a major expansion of Medicare benefits under the catastrophic health insurance program.

While we recognize that there may be some physicians who either overcharge for services or who provide services for which the payment levels are inappropriate, we do not believe that the piecemeal approach of freezes and selected

price cuts is an appropriate way to curb the problems that may exist with the Medicare program. We must all remember that, by and large, the program has been extremely successful in its goal of trying to increase the access of the elderly to mainstream medical care. AUA is very concerned that the benefits of Medicare have been eroding in recent years. We urge Congress to take steps to halt that erosion.

Part 2 - Report of the Physician Payment Review Commission

Congress created the Physician Payment Review Commission in 1986 in an effort to provide it with expert advice on ways to modify the physician payment system under the Medicare program. Congress was particularly interested in the advice of PPRC on the development of a national fee schedule for Medicare. PPRC has issued its second report and has laid out for itself a heavy agenda of important activities, with a special focus on developing a fee schedule based on a resource based relative value scale (RB-RVS), such as the one now being developed by William Hsaio at Harvard.

First, AUA would like to provide an overview of its experience with PPRC over the last two years. In many ways it has been a frustrating one because of our deep concern about the methodology used to identify TURP as a "overvalued" procedure. We were particularly concerned when PPRC became involved in short-term budget reduction recommendations, rather than focusing on long-term policy development. AUA recognizes the fact that certain members of Congress had asked for advice on the short-term budget problem, but we believe that PPRC could have gracefully and successfully declined to become involved in these activities which are quite far removed from its legislative mandate. The diversion of PPRC's time and energy that went into the "overvalued" procedures debate was unfortunate and the effort did not increase the prestige of the Commission in the eyes of many medical groups.

It is fair to say that many medical organizations had been reasonably supportive of the Commission because it presumably offered the opportunity for debate over major policy issues without the pressure of short-term budget politics. Many groups were disappointed when they learned that this was not the case. We hope that PPRC will choose to avoid the short-term budget debate in 1989, when pressures to reduce spending will again be severe. PPRC should not become just another staff arm to the Congress. We believe that is contrary to the statutory intent and best use for the organization.

While we have always found the staff and Commissioners to be reasonably accessible, we have been concerned that the membership of the group does not reflect the views and experience of practicing surgeons. Too many of the physicians who are involved are removed from daily medical practice. AUA believes that more emphasis should be placed on involving private physicians who are seeing patients. AUA hopes that over time this imbalance in membership can be addressed by Congress.

Congress has several times expressed a commitment to developing a fee schedule for payment of physicians under Medicare. AUA believes that this can be a positive direction to move in and that it can offer an opportunity to address many issues in the current payment structure. PPRC is also committed to the development of a fee schedule, particularly one based on a resource-based relative value scale. As noted, the major work on a RB-RVS is being done by William Hsaio, Ph.D. at the Harvard School of Public Health under contract to the Health Care Financing Administration. The American Medical Association is a subcontractor to that project but this in no way means that medicine generally accepts what is being done at Harvard. To the contrary, many medical organizations, including AUA, have expressed grave concern about the directions being taken in the Harvard project. We are eagerly looking forward to the opportunity to review the report in detail when it is available this summer. PPRC has indicated that it will commit major resources to the review of the Hsaio

study and that it will do everything it can to make that review accessible to physician organizations and other interested groups. AUA thinks that is a very positive step by PPRC and looks forward to participating in these activities.

As noted we have serious reservations about the work of Dr. Hsaio. This is based in part on his previous work in Massachusetts and also on reports from AUA representatives to the current Hsaio study. We are very hopeful that Congress will not quickly embrace the results of this study but will permit a full and vigorous debate about its merits. We are very concerned that the biases of the principal investigator, as well as limitations in the survey design, sample size, and algorithm will lead to unrealistic relative values. Since the Harvard RB-RVS may well become the basis not only for Medicare payment, but also payment by other third parties, we believe that a great deal of deliberation must take place before it is accepted. AUA intends to participate vigorously in all aspects of that debate.

AUA does not object to the concept of using a resource-based relative value scale as the basis for developing a national fee schedule; however, we are not certain that the one currently under development at Harvard is the right one. We recognize the need to address the problems in physician payment under the Medicare program; however, we would caution that the system has worked reasonably well to date in terms of providing high quality medical care to beneficiaries. Unless we can be assured that a substitute payment system will maintain the same level of quality and service for the patients we should be very careful about making a change. AUA believes that any efforts to implement a fee schedule based on RB-RVS should be done on a trial basis first.

The experience with the Medicare prospective payment system (PPS) for hospitals is instructive. Here a relatively untried system was instituted in all hospitals. Rather than relieving Congress of legislative burdens, it has spawned a whole new series of problems for Congress. Reconciliation bills now read like the tax laws as Congress makes an effort to correct the many small problems inherent in PPS. AUA strongly recommends that more consideration go into the development of a physician payment system than went into the development of the Medicare hospital payment system.

Another reason for being very cautious about making major changes in physician payment is the sheer complexity of the physician payment system which involves some 39 million encounters with 400,000 physicians annually, a far more complex administrative burden than 7,000 hospitals and 11 million patients. William Roper, M.D., Administrator of HCFA, has recently cautioned the Ways and Means Committee Health Subcommittee about some of these administrative problems and we concur entirely with his view.

Development of an RB-RVS fee schedule may address some of the issues in Medicare but does not deal with the issue that has driven the Medicare debate in recent years -- the impact of the program on the budget. Program growth is well documented, although the causes for that growth are not entirely agreed upon. Looking at the changing demographics of our society it is reasonable to expect that vigorous program growth will continue absent draconian measures to control its expansion. As the PPRC report notes, simply changing the payment schedule is not necessarily going to address any other issue. Some utilization controls will be necessary if program growth is to be limited.

A major commitment to research on outcomes and utilization should be made. There is no question that medicine is based on science but is also very much an art. There are substantial gray areas where physicians can reasonably differ on the choice of services to be provided to a

patient. It is difficult in many areas to draw hard and fast lines saying "This should be done" or "This should not be done." We strongly urge that the government fund more research on the outcomes of various services and procedures and that this research be done in conjunction with physicians both in academic and private practice settings.

We also encourage the government to work jointly with physicians to develop standards of care and indications for use that can help guide payment. While we are concerned about "cookbook" medicine or the misuse of these standards, we do believe that a substantial benefit can accrue to the public from such work. AUA recognizes that some savings may flow from this effort, but more importantly believes that it will ensure better medical care for Medicare beneficiaries as well as other patients. Therefore, we are encouraged that PPRC's report to Congress outlines a number of activities in this area. While we realize that development of standards and indications is difficult, we believe that it can be done for many areas of medicine. AUA looks forward to working with PPRC on these issues.

Part 3 - Federal Register Notice for the Health Care Financing Administration.

AUA believes that the Federal Register notice on payment of specialty differentials is premature. Given the major studies and review now going on regarding appropriate physician payment, we think that any important change to the current system should be deferred until such time as the conclusions of these studies can be evaluated. Indeed it is the goal of the Harvard RB-RVS to design a payment system that more closely compensates based on the resources physicians bring to a service or procedure. Two of those resources are skill and training. The training of a specialist is often an extremely important part of the service. While this special expertise is not always necessary, it certainly should be encouraged when it is important. Any modification of the payment system that lessens the availability of necessary, specialized medical care is to be discouraged. Every specialist can cite countless tales of patients who are referred too late for optimal medical care. The payment system should not be structured in any way to encourage slow or delayed referrals. We believe that any discussion of specialty differentials has to be part of the larger physician payment debate and we have urged HCFA not to proceed on this course.

Conclusion

The American Urological Association is very pleased to have the opportunity to submit these comments for consideration by the Aging Committee. AUA believes that too many changes have been made to Part B of Medicare in recent years based solely on achieving a level of budget savings. Insufficient consideration has been given to the level and quality of medical services that should be available to program beneficiaries. AUA hopes that the activities of the Special Committee on Aging can help reverse that trend.

O

89-274 (120)