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Physician payment reform: don't forget the patient
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As organized medicine follows the development of various proposals for reforming the Medicare physician payment system, it is increasingly clear that the overriding objective of policymakers who seek to reform Medicare Part B is to cut program costs. Unfortunately, the role of Medicare patients has received relatively little attention in the debate over Medicare physician payment reforms. Therefore, I address several aspects of Medicare physician payment reforms focusing on the patient. I begin with a discussion of the Medicare program’s objectives, followed by an outline of the basic components of an equitable Medicare payment system for physician services. My final remarks focus on the importance of reimbursement rates in determining access to care, and the role of Medicare patients in determining the volume of services provided.

Conflicting Medicare Objectives

At its inception, the primary objective of the Medicare Part B program was to provide elderly Americans with affordable “access” to mainstream health care. However, Congress and the Health Care Financing Administration (HCFA) have never explicitly defined access, either legislatively or through federal regulation. Lawmakers, administrators, and researchers have frequently used the word “access” to describe the foremost objective of the Medicare system, but there has been little research or managerial attention to developing an operational definition of access.

From my perspective, the failure to define explicit access objectives has resulted in a subtle displacement of access by short-term cost cutting as the major concern of Congress. Paul Ginsburg confirms this view in his description of budget reconciliation in this volume. Over the years, Congress has introduced a number of programs designed to modify the existing physician payment system, including limitations on prevailing charge screen updates, the participating physician program, a freeze on

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physician fees, and maximum allowable actual charge (MAAC) legislation. These programs attempted to strike a balance between the conflicting goals of access and budgetary restraint, but the result has been a distorted and unwieldy reimbursement system that pleases no one.

To avoid repeating the errors of the past, I believe that it is essential to include the patient explicitly as an integral component of determining physician payment levels. Failure to include the patient in the reimbursement equation will result in a Medicare payment schedule that distorts the price of physician services and wastes valuable health care dollars. Congress will enact more measures aimed at curing the “symptoms” of inadequate access and waste without addressing the “disease” that is embodied in the inadequacies of the pricing mechanism.

Goals For A Medicare Payment System

A variety of different proposals have been made concerning potential reforms to the Medicare Part B system, including expenditure targets, physician diagnosis-related groups (DRGs), capitation programs, competitive bidding, or the use of a resource-based relative value scale (RBRVS) as the basis of a payment schedule. Regardless of what reimbursement system ultimately is adopted, access to care will be jeopardized unless the new reimbursement system is designed to reflect the needs of the Medicare patient. This goal can be accomplished if the new Medicare reimbursement system relies on three basic principles.

First, any new payment scheme should be designed to reflect the “resource cost” of providing services to patients. This will ensure a fair and equitable payment system, which, in turn, will encourage physicians to treat Medicare patients. Organized medicine feels that this could be accomplished by using the Harvard RBRVS as the basis for a Medicare indemnity payment system if it were sufficiently expanded, corrected, and refined. These modifications include an appropriate restudy of services for which data are insufficient, an improvement in the measure of practice and training costs, an expansion of the study to more specialties and services, and development of a method for determining appropriate relative values for visits.

Second, the Medicare payment system should reflect valid and demonstrable geographic differences in practice costs. This is necessary to ensure that patients living in high-cost areas are able to afford the same access to care as patients living in low-cost areas.

The third, and most important, element of any new Medicare payment system is the ability of physicians to determine their own fees. Many stakeholders in the debate over Medicare reform feel that allowing
physicians to establish their own fees (that is, “balance bill”) and accept assignment on a claim-by-claim basis has only served to increase physicians’ incomes at the expense of patients. However, a more careful examination of the market for physician services indicates that balance billing is essential to maintaining access to the full range of physician care.

To understand the relationship between access and balance billing, it is instructive to consider the alternative. Under a reimbursement system that prohibits balance billing, physicians will be unable to charge an amount in excess of the Medicare allowed rate. On the surface, this may appear to increase access because it reduces patients’ out-of-pocket expenses. However, this reasoning ignores the fact that Medicare patients purchase services in markets where prices generally reflect supply and demand. If Medicare payments are too low and physicians are barred from balance billing, the number of physicians willing to treat Medicare patients will be reduced. Ultimately, this will result in a two-tiered medical care system in which Medicare patients cannot see the full range of physicians. In short, price controls will limit access to care under Medicare just as they have under Medicaid in many states.

A second argument in favor of allowing physicians to determine their own fees involves the complexities associated with determining Medicare payment levels based on “resource costs.” The task of determining the appropriate relative values and conversion factors for over 7,000 services across different geographic regions certainly will result in payment amounts that differ from their “correct value.” Combining these erroneous payment levels with a system that prohibits balance billing essentially “locks in” incorrect prices. It is, therefore, essential that balance billing serve as a safety valve in any new reimbursement system. This will ensure access to care even though Medicare payment levels are incorrect. In economists’ terms, balance billing will provide the means by which prices can adjust and play their vital role in the market adjustment process.

Finally, some researchers have suggested that capping physician fees will cause Medicare expenditures to increase. Under a price ceiling, demand for services may increase since the average price of services has been reduced. Alternatively, some researchers have suggested that physicians may attempt to maintain their incomes under maximum fee limits by increasing the volume/utilization of the patients they serve. I discuss the specific issue of volume/utilization below.

**Patients And Volume**

Until recently, little has been known about the underlying causes of growth in Part B “volume and intensity” of service that accounts for a
large proportion of the increasing dollar outlays of the program. Over the past year, however, new research has provided some insight into the nature of the growth in volume. Specifically, Department of Health and Human Services (HHS)-financed contractors have been examining detailed data obtained directly from a few of the Medicare carriers; the detail in the carrier data is much greater and more informative than that which HCFA has used to examine trends in volume growth. It is now possible to begin to replace much of the previous speculation about the possible components of that growth with facts from better data.

The first available results from this new research have been presented to the Physician Payment Review Commission (PPRC). The research shows that (1) measuring "volume" by real expense per enrollee versus real expense per claimant may lead to radically different conclusions about causes of the growth in Part B; (2) the major sources of growth have been the expanding use of outpatient department (OPD) surgery and growth in the proportion of eligible patients receiving services; (3) the expanding use of OPD surgery has resulted in increasing the average allowed charge per service across all services, a common measure of "intensity;" and (4) some evidence of upcoding of office visits was found, but upcoding in the aggregate (including procedure upcoding) explains only a small percentage of the increase in Part B allowed charges.

At a recent research conference on Part B volume growth held by the Leonard Davis Institute for Health Economics of the University of Pennsylvania and jointly sponsored by the American Medical Association (AMA), there was substantial agreement among economists that the nature of volume increases evident in this new information is largely a manifestation of increases in demand for services.

Demand has increased for two reasons. First, technological change has made available more procedures on an outpatient basis, which lowers both the time and psychic costs to the patient contemplating such procedures. Second, the economic cost to patients also has been reduced for a variety of reasons. For instance, physician fees have been placed under a number of different restrictions since 1984. The fee freeze, when combined with a growing nominal income for the elderly, results in an actual decrease in the real cost of physician services paid by Medicare patients. Also, the increasing physician participation and assignment rates experienced throughout the decade have reduced out-of-pocket costs to patients, offsetting to a large extent legislated increases in the Part B deductible and premium. At the same time, more than 70 percent of aged Medicare enrollees have "medigap" insurance, while an additional 8 percent are covered by Medicaid. These two factors effectively neutralize Medicare's cost-sharing provisions.
The past year also has brought forth extensive discussion of the “appropriateness” of medical care received by Medicare patients. In the debate over appropriate care, a belief has emerged that an opportunity exists for achieving substantial budget savings by eliminating all of the “unnecessary” or “inappropriate” medical care. Such a view of the possibilities for cost savings fails to consider many of the basic forces generating the demand for medical care. In particular, organized medicine is concerned that the role of the patient in making choices about medical care is minimized. Recent trends in Medicare physician expenditures suggest an increasing role for patients in the demand for health care. First, availability of information has a profound influence on demand; witness the surge in demand for colonoscopies following the press coverage of President Reagan’s colon-cancer surgery. Second, availability of more options for treating many conditions, especially outpatient surgery, invites the application of more subjective criteria for choice. Third, erosion of incentives for patient cost-consciousness further increases the weight of subjective criteria in choice of medical care.

In short, defining “inappropriate” care on the basis of strict technological criteria, retrospectively applied, may overstate the actual volume of truly unnecessary services. Instead, the definition of appropriate care should be expanded to include both the subjective preferences of patients and the patient’s increasingly important role in medical treatment decisions. Policy that does not recognize the role of patients’ preferences and tries to eliminate “inappropriate” care will cultivate resentment and resistance on the part of both patients and the physicians who represent and advocate their interests. A more appropriate approach is to provide incentives that reward patients for making more efficient choices among alternatives; this approach provides physicians with the flexibility to use their medical skills and knowledge within a range of options.

Conclusion

The physician community is concerned that continuing to neglect the role of patients in the debate over Medicare reform ultimately will result in a payment system that is inequitable, overregulated, and wasteful of precious health care dollars, and that will not provide adequate access to health care for elderly Americans. Although it may appear counterintuitive, I believe that access to high-quality health care can only be guaranteed if physicians are allowed to determine their own fees. Many others have made the point that balance billing provides a safety valve that corrects for payment levels that are artificially restrained. Moreover, allowing physicians to determine their own fees guarantees an adequate
stock of physicians who are willing to treat Medicare patients and gives patients access to a wider range of choices regarding their personal health care.

NOTES

3. A comprehensive measure of resource costs should include the inputs purchased by the physician (for example, staff, equipment, professional liability insurance, and supplies), the cost of training, and the opportunity cost of the physician’s time. Opportunity costs are those incurred by the physician treating a Medicare patient relative to a non-Medicare patient.
4. Balance billing refers to physician charges in excess of the Medicare allowed charge.
6. This observation is supported by I. Welch, “Prospective Payment to Medical Staffs: A Proposal,” Health Affairs (Spring 1989); and Holahan and Zuckerman, “Medicare Mandatory Assignment.”
8. This concept has been presented by J. Lomas et al., “Paying Physicians in Canada: Minding our Ps and Qs,” Health Affairs (Spring 1989); and Mitchell et al., “The Medicare Physician Fee Freeze.”
9. P. McMenamin and L. Marcus, ‘Changes in Medicare Part B Physician Charges: Final Report,” DHHS Contract no; 100-85-0053 (Mandex, Inc., October 1988). Mitchell and colleagues present their analysis of the increased volume of Medicare services in this volume of Health Affairs. While their data appear to be similar to the data used in the study referenced above, the conclusions and methodology seem to differ. However, because the final report by the Health Care Financing Administration of the Mitchell study has not yet been released, it is not possible to draw conclusions about these differences at this time.
10. If the proportion of patients who use services in a year grows faster than the total number of patients eligible for Medicare benefits, then average expenditures per enrollee will increase faster than average expenditures per user.