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PHYSICIAN PAYMENT POLICY IN THE 101ST CONGRESS

by Paul B. Ginsburg

Prologue: Somehow, every society must determine how physicians are rewarded financially for the medical care they provide to patients. When Medicare was created in 1965, the federal government embraced the traditional fee-for-service method and oriented its payment levels to charges then prevalent. Now, almost thirty years later, medical care costs that continue to rise more rapidly than the cost of virtually all other goods and services, and the federal government’s own budgetary crisis, are compelling Congress to consider reforming the way Medicare pays physicians. The task, however, will be far more complex and politically difficult than changing the method by which Medicare pays hospitals, if for no other reason than the numbers involved. Medicare’s Part A involves some eleven million admissions to 6,800 hospitals for 475 diagnosis-related groups. Medicare’s Part B involves 350 million claims from almost a half million practicing physicians for 7,000 different procedure codes. In this paper, economist Paul Ginsburg, who is executive director of the Physician Payment Review Commission (PPRC), provides a primer of the vexing issues that Congress must consider when it addresses payment reform. Ginsburg, who holds a doctorate in economics from Harvard University, joined the PPRC at its creation in the fall of 1986. Since that time, the commission, which operates with a budget of $3 million and a staff of twenty, has evolved into the most active and visible forum at which citizens, government, the medical profession, and other parties with a vested stake in physician payment issues discuss these questions. Ginsburg, who previously worked at the Congressional Budget Office as its chief health policy analyst (1978–1984) and The RAND Corporation (1984–1986), has established a solid reputation as a nonpartisan participant in policy making. He is an advocate of the adoption of a Medicare fee schedule, a policy direction in which the PPRC is strongly leaning.
Almost twenty years elapsed between the compromises that led to the last-minute creation of Part B of the Medicare program and the beginning of a serious focus on reforming its mechanism for paying physicians. Starting in 1984, however, four successive years of legislation have established a direction for change and provided for development of the infrastructure to accomplish it. While policy initiatives might not have gotten off the ground if not for the huge cost problem this country has faced, research findings of inappropriate care and seemingly erratic patterns of fees have reinforced policymakers’ resolve to reform the payment system. Many expect substantial activity by the 101st Congress.

This article is offered as a primer for those planning to follow federal policy toward physician payment over the next two years. In the article I first describe the forces driving policy and the recent steps that have been taken to prepare the way for change. I turn next to the process within which policy is made: budget reconciliation. The core of the article is devoted to the two issues likely to get the most attention over this period: a Medicare fee schedule based primarily on costs, and policies to slow the increase in the volume of services in the context of fee-for-service payment. I conclude with a discussion of the longer-run themes that will begin to be addressed over the next two years.

Background

Following its approach regarding hospital payment in the Medicare program, the federal government has addressed physician payment from the perspective of a large purchaser. It has been driven in large part by budget needs but also has given careful attention to the interests of major constituent groups—beneficiaries and physicians. While little consideration has been given to the interests of other payers, the fact that Medicare is less dominant a purchaser of physician services than of hospital services has led to more cautious approaches. Policymakers know that the degree to which private payers follow Medicare initiatives will affect the magnitude of reform that can be attempted, so consideration of attracting others to emulate new payment patterns will get increasing attention.

Budget reconciliation. A full understanding of recent policy changes and the prospects for further change requires a basic familiarity with the federal budget process, especially the process of budget reconciliation. Seeking to play a larger role in budget policy, Congress wrote legislation in 1974 to establish procedures by which it could consider the federal budget as a whole and have a greater say in the major resource allocation
decisions. It also created institutions to make the process work—a budget committee in each house and the Congressional Budget Office (CBO). Both the law and the institutions that it created proved to be flexible. Thus increasing concern in 1980 over the size of the federal deficit initiated a process of budget reconciliation that was very distinct from what was envisioned in the 1974 legislation.

Budget reconciliation involves legislative changes to reduce spending in a wide range of programs (and often raise revenue as well) to meet a particular deficit reduction objective. The process is particularly important for entitlement programs, which would not otherwise be reviewed regularly. Thus, for Medicare, budget reconciliation means frequent changes in provisions defining eligibility, benefits, and payment of providers.

As part of the joint resolution that Congress writes each year to set out its overall budget objectives, each committee with authority over spending receives a directive concerning total outlays to be permitted for programs under its jurisdiction for each of a number of fiscal years. Usually, reaching the specified outlays requires reductions in spending from the levels projected under current law. Authorizing committees apportion these spending reductions among programs for which they are responsible and specify program changes to meet the targets. The CBO determines the budget impact of each program change and keeps score.

For Medicare physician payment, a number of decisions are relevant: (1) the overall level of federal spending that is targeted; (2) the portion of the spending reduction that is allocated to the committees with jurisdiction over Medicare Part B; and (3) the decisions that these committees make concerning the role that reductions in physician payment will play in meeting their spending targets. In the past, reductions in physician payment have been proportionately smaller than reductions in hospital payment.

Recent legislation. Frequent use of the budget reconciliation process has led Congress to write four major pieces of legislation since 1984 that have dealt with Medicare physician payment policy. Rather than tracing the evolution of policy year by year, I describe the total change in policy over the entire 1984–1987 period.

For those not familiar with methods used by Medicare to determine payments to physicians, the essence of “customary, prevailing, and reasonable” (CPR) payment is to pay physicians what they charge, subject to two screens. The customary charge screen compares a physician’s submitted charge for a particular service to what the physician customarily charged during the previous year. The prevailing charge screen for the service is the 75th percentile of customary charges of physicians (often in
a particular specialty) in the locality. Since 1975, the rate of increase of prevailing charge screens has been constrained by the Medicare Economic Index, which tracks increases in practice costs.

Since 1984, policy has focused on three principal areas: changes in payment rates, limitations on balance billing (amounts charged by physicians in excess of the Medicare approved charge), and creation of an infrastructure for further policy change. With policy being budget-driven, it should not be surprising that payment rates have been held back. This began with a 1984 freeze in Medicare payment rates and evolved toward annual increases that were smaller than previous formulas would have permitted. With the exception of the freeze, however, all of the payment limitations applied only to prevailing charge screens, so that physicians whose charges were below the levels of these screens were not affected.

More significant was the selectivity of payment constraint. Specific services were singled out for substantial payment reduction because they were considered overvalued by Medicare relative to other services. Primary care services (defined as office visits, nursing home visits, home visits, and emergency room visits) were exempted from additional payment constraints applied to other services. A geographic dimension to policy was also introduced, so that reductions in overvalued procedures varied among localities according to how the prior prevailing charge in each area compared to the national mean for each procedure.

Significant limits were placed on physicians’ abilities to charge patients the difference between their submitted charge and the amount allowed by Medicare. The 1984 freeze prohibited increases in fees charged to Medicare beneficiaries. It was replaced by a series of limits on charge increases (known as maximum allowable actual charge, or MAAC, limits). The MAAC limits are complex, but revolve around a key number—115 percent of the prevailing charge. Physicians can raise charges up to this amount over four years, but for those charges exceeding that amount, annual increases are limited to 1 percent. A version of the MAAC limits was applied to those procedures identified as overvalued. After a transition, charges for these procedures are limited to 125 percent of the reduced prevailing charge levels.

Congress created the category “participating provider” to increase patients’ opportunity to identify physicians who take assignment. A physician or other provider could obtain this designation by agreeing to accept assignment on all Medicare claims. Participating physicians are not restricted by MAAC limits in the amount they can charge and have prevailing charge screens that are 5 percent higher than those of nonparticipating physicians. They also are listed in a directory that is distributed
to beneficiaries.

Congress took two steps to develop the infrastructure to pursue further policy change. It mandated the Secretary of Health and Human Services to conduct a relative value study and make recommendations to Congress concerning a fee schedule based on the study. It also created the Physician Payment Review Commission (PPRC) and asked it to make annual recommendations concerning relative payments, assignment and balance billing, and increases in utilization of services over time.7

To summarize, policy thus far has had a clear and consistent direction. Relative payments for different services and across geographic areas are to depart from historical patterns. Physicians are encouraged to accept assignment and are subject to limits on balance bills when they do not. In contrast to relative payments and balance billing, however, no direction has been set as to how to slow the increasing rate of utilization of services in Medicare.

A Medicare Fee Schedule

The 101st Congress is likely to seriously consider a fee schedule for Medicare. A fee schedule, which specifies either the amount to be paid or the maximum that can be paid for each service, would replace the current method (CPR) by which submitted charges are screened for reasonableness.

Rationale for a fee schedule. A fee schedule would have three major components—a relative value scale (RVS), geographic and (possibly) specialty multipliers, and a conversion factor. The RVS establishes what each service or procedure will be paid relative to others. The same relative value scale likely would be used in all localities, but payments would vary from one geographic area to another, perhaps on the basis of a geographic index of practice costs. A conversion factor translates the relative values, altered by multipliers, into dollar amounts of payment. The conversion factor could be set to pay in the aggregate the same amount to physicians as before, or more or less.

A fee schedule would accomplish a number of objectives. Perhaps most important, it would provide a mechanism for wholesale revision of the pattern of relative payments. Many regard the current pattern of payments as significantly distorted from what a hypothetical perfect market would produce. The extensive but uneven use of health insurance and the difficulty of patients who are worried and in too much pain to act as rational consumers keep market forces from driving price down to marginal costs. Empirical evidence for the magnitude of the distortions comes from the recent relative value study by William Hsiao and his
A fee schedule that moved the pattern of relative payments closer to that of a hypothetical perfect market would provide a more suitable set of incentives to physicians and would improve equity among physicians. While financial incentives are certainly not the prime determinant of practice decisions by physicians, many suspect that they are relevant—for example, at the margin of devoting additional time to history and physical examination versus performing diagnostic tests. Financial incentives might also affect decisions concerning specialty choice and practice location.

Many physicians regard the differences across procedures in revenues per unit of time to be too large to be justified on the basis of differences in intensity of effort and required training. For example, the Hsiao study estimates that a general surgeon spends 3.4 times as long performing a gall bladder operation as performing a comprehensive office visit and devotes 1.8 times as much work per minute, but is paid twenty-four times as much by Medicare.

Likewise, much of the geographic variation in fees cannot be justified on the basis of variation in costs of practice, whether defined narrowly, to include only overhead, or broadly, to reflect varying opportunity costs of the physician input. Unexplained geographic variation is most striking when one compares charges for specific services in similar areas. For example, the 1984 prevailing charge for total hip replacement in Washington, D.C. was $1,547, compared to $4,126 in New York City, while the respective prevailing charges for a comprehensive office visit were $83 and $72. In an environment of continuing payment and charge constraint by Medicare, these issues of equity are taking on greater importance.

A fee schedule is more than a device to realign relative values, however. Administratively, it is a much simpler method of determining payment rates. A fee schedule would end the need for maintaining fee profiles for each physician for each service and for calculating prevailing charge screens. It would facilitate many policies to manage the payment system more tightly, such as a precise and uniform definition of what services are included in global fees for surgery and other procedures. Politically, it could facilitate dialogue and agreements between the federal government and the medical profession.

Needless to say, a fee schedule has detractors, who raise a number of important objections. Some people question whether the perceived benefits are large enough to justify the degree of change and redistribution involved. Others are concerned that Medicare beneficiaries would lose access to care if Medicare payments diverge from the current patterns...
followed by private payers. This will depend both on the degree to which private payers follow Medicare's lead and on the degree of sensitivity of markets for physician services to differences in payment rates. Still others worry about whether physicians will react to the altered relative prices in ways that are contradictory to the goals of the fee schedule. Economists cannot agree whether, at least in the short run, physicians will increase or decrease the volume of those services for which payments are reduced.

Indeed, the nature of the current market for physician services is critical to the potential of a fee schedule. If markets corresponded closely to the textbook ideal, few would see the need for a fee schedule that changes the pattern of relative payments. Most feel that markets for physician services do not follow the ideal very closely, but our knowledge of how they actually do function is limited. Research has been difficult because of both limited data on physician services and the lack of natural experimentation in physician payment in the United States.11

Developing a fee schedule. As noted above, the seeds for the development of a fee schedule for Medicare have been planted for some time. Congress mandated a relative value study by the Reagan administration, created the PPRC, and mandated that it develop recommendations on relative payment issues. In 1988, the PPRC recommended a fee schedule with a relative value scale based primarily on resource costs and outlined how it would develop a detailed proposal in its 1989 report to Congress.

The relative value scale. In September 1988, Hsiao completed the first phase of the congressionally mandated study and published a relative value scale for eighteen specialties.12 Hsiao defined a concept of “work” that encompassed the time, mental effort and judgment, technical skill and physical effort, and stress involved in a service or procedure and surveyed practicing physicians to have them rate the work involved in various procedures. His relative value scale differs substantially from the pattern of current charges, with evaluation and management (EM) services valued more highly and technical procedures valued less.

The PPRC is using the Hsiao scale as a starting point in its work to develop a fee schedule proposal for Congress. It is evaluating the study carefully and conducting an extensive process of getting comments from groups representing physicians, beneficiaries, insurers, and other interested parties. The evaluation covers a wide scope, including assessment of the validity of the results from both a methodological and clinical perspective, simulation of the impacts of a Medicare fee schedule based on this RVS on physicians and beneficiaries, and modifications to the RVS.

At this point, the PPRC envisions modifications in at least three major areas. First, the formula by which practice costs are incorporated into the
relative value scale needs to be revised. In the original Hsiao formulation, estimates of the relative work by the physician affected not only the component of the fee that rewards the physician for time and effort but also the component that covers practice costs. This inadvertently magnified by a substantial margin the degree of change from current relative values. For example, a preliminary RVS developed by the PPRC that is based on the Hsiao study has coronary artery bypass graft surgery fees declining 33 percent, in contrast to the 66 percent decline reported by Hsiao. The reduction for cataract surgery would be 24 percent instead of 56 percent, as Hsiao suggested.

The PPRC is also attempting to develop a formulation in which practice costs are aggregated by broad type of service (for example, office visit, hospital invasive procedure) rather than by specialty. Besides offering the potential of greater accuracy, such an approach would decrease rather than increase the emphasis on specialty differentials.

The second area for revision concerns relative work values among EM services (visits and consultations). Coding for EM services tends to be much less precise than for surgery or technical services. Physicians within and across specialties interpret visit codes differently and use them to represent services that are heterogeneous in terms of time and work. Thus, any vignette in the Hsiao study is not likely to be representative of a particular visit code. Although the Hsiao method stands a good chance of obtaining a reasonably accurate estimate of the relative time and effort between EM services in general and other types of services, it is unlikely to produce accurate relative values among EM services.

Data analysis by the PPRC has indicated how poorly current codes for EM services reflect the differences in the resources expended by physicians. This is especially true for the levels of service (for example, brief, limited, intermediate) that differentiate visits within each class of EM service (for example, new patient office visits). PPRC analysis of raw data from the Hsiao study suggests that time is more reliable than current levels of service in predicting work within a particular class of visits. Reform in the method of coding that would incorporate time in the definition of level of service would allow the development of more accurate values for EM services based on the estimated relationship between work and time. The commission is considering such reforms and is developing refined values for EM services using raw data from the Hsiao study and a new log-diary survey of physicians’ visits and consultations.

The third area for revision of the Hsiao RVS concerns definitions of global surgical fees. Traditionally, the fee for a surgical procedure has covered many operative procedures and postoperative care. The specifics
of these policies vary from carrier to carrier, however, and avoiding double payment for services has been less than perfect. The commission has used consensus panels to develop a standard definition of global fees for surgery. The estimates of relative values for surgery will have to be adjusted to reflect the new policy.

Medical specialty societies have also been studying the Hsiao RVS and have raised specific problems that affect the relative values for their specialty. Many of these appear to be valid and warrant attempts to correct them. The second phase of the Hsiao study will be able to deal with some of these, but additional methods, such as intraspecialty consensus panels, may be needed as well. The commission is contemplating organizing such a process.

Other aspects of the fee schedule. While the RVS has gotten most of the attention in the media to date, other components of the fee schedule are likely to be equally, if not more, controversial. Geographic multipliers and policies on assignment and balance billing are the most important. The concept behind the RVS—that costs should determine relative payments—applies to geographic variation as well. It often seems that every physician is aware of colleagues in other localities that get paid more than they do for a particular procedure; believes that the difference is not justified on the basis of practice costs, and has complained to his or her congressman about it. Members of Congress representing rural areas have a particularly strong interest in reforming the pattern of geographic variation.

Many fee schedule advocates agree that geographic multipliers should reflect a geographic cost-of-practice index. The Urban Institute has developed a variety of preliminary indices for the Health Care Financing Administration (HCFA) and is refining them. What should be included in the index is subject to debate. While most agree that differences in the prices of office space and nurses’ wages should be reflected in payments to physicians, debate continues on whether payment for the opportunity cost of the physician’s time should vary. In a hypothetical perfect market, payments to physicians for the opportunity costs of their time would vary on the basis of what it would take to get a sufficient number to locate in an area. This concept could be approached by using an index of earnings of nonphysicians. But others assert that equitable payment would require uniform valuation of the physician input.

Consideration of a fee schedule is also directing attention to policies on assignment and balance billing. The American Association of Retired Persons (AARP) has stated that once the payment structure is rationalized, assignment should be mandatory. The American Medical Association (AMA) continues to emphasize its strong opposition. If one looks at
recent federal legislation, a potential middle-ground option is apparent. Recent policy has encouraged voluntary assignment through the participating provider category but also has placed direct limits on the size of balance bills. For example, 1987 legislation developed a fee schedule for services provided by radiologists. After a transition, charges for these services will be limited to 115 percent of the fee schedule amount.

### Slowing Growth In Volume Of Services

Medicare outlays for physician services have grown rapidly in recent years. From 1975 to 1986, outlays grew nearly 18 percent annually. An important part of this growth has reflected increased volume of services per enrollee, which grew 8.5 percent annually between 1980 and 1985. Volume growth captured the attention of the general public in September 1987 when the Part B premium was increased by 39 percent.

While the premium increase generated a great deal of “finger pointing” concerning the role of physicians’ versus beneficiaries’ decisions in the rising volume of services, most accept the need for constraint. Most also agree that no matter what the long-run potential of capitation in Medicare, some success in containing volume of services under fee for service is essential. Most policy attention likely will focus on two options—one involving effectiveness research and practice guidelines and the other using expenditure targets.

**Effectiveness research and practice guidelines.** Recent research has suggested that substantial amounts of ineffective care are delivered because of lack of knowledge by physicians as to the risks and benefits of procedures. In some cases, research evaluating effectiveness or optimal uses of a procedure simply does not exist. John Wennberg attributes much of the small area variation that he finds to local norms remaining distinct because of the absence of research results suggesting optimal treatment. In other cases, the results have not been sufficiently disseminated to practicing physicians. The recent studies by Mark Chassin and colleagues, in which leading physicians have developed a consensus as to what are the appropriate indications for use of a procedure, document substantial use of services that are “clearly inappropriate.”

During the past two to three years, increased resources have been committed to research on effectiveness. Congress has authorized the National Center for Health Services Research to make grants for research on “outcomes” and provided some funding. HCFA has begun to organize its vast claims databases to support research on effectiveness by intramural and extramural scholars. Major issues over the next two years concern the level of federal resources that are to be committed to these
and other efforts to increase our knowledge of effectiveness and the structural framework for these activities.

Development and dissemination of practice guidelines is being pursued to provide the practicing physician access to the results of effectiveness research. To date, a number of medical specialty societies have developed practice guidelines, with the American College of Physicians the most active. In addition, researchers at The RAND Corporation have developed guidelines in the course of conducting research on variation in use of services. Recently, the AMA announced a major effort with The RAND Corporation to develop practice "parameters." Practice guidelines or parameters can affect patterns of use of services both through the provision of educational material to physicians and through the development of sound criteria for utilization review.

An issue before the federal government now is whether to use public funds to increase the magnitude of efforts in this area. Few would advocate that the government develop the guidelines itself, but it could support efforts by medical societies and private researchers to do so. Along with funding, the federal government could participate in setting priorities and improving the techniques for development and dissemination.

 Needless to say, the relationship between guideline development and cost containment is uncertain. A practice guideline might help to eliminate inappropriate care and save the costs of such care, but in other instances it might increase the intensity of services used for diagnosis and treatment by apprising the practicing physician of additional effective procedures. While the appropriateness and quality of care would increase, costs might increase as well. In addition, experience of previous efforts to use education to affect practice behavior has been decidedly mixed. This has led many to maintain that incorporation of guidelines into utilization review criteria would be essential for success.

**Expenditure targets.** Expenditure targets would provide a collective incentive to physicians in an area to contain the volume of services delivered to Medicare patients. For a defined geographic area, a target of expenditures per Medicare enrollee would be established on the basis of area spending in a base year and a target rate of increase. Comparison of target spending with actual spending would lead to positive or negative performance adjustments to be applied to the following year's payments.

While expenditure targets would use financial incentives to change physicians' behavior, the incentives would not be directed to the individual physician, but instead to area physicians collectively. If targets were to have their desired effects, physicians would need to organize themselves to contain costs. Collective activities could include additional develop-
ment and dissemination of practice guidelines by physician organizations and others, additional participation by practicing physicians in the work of peer review organizations, and even more frequent reporting of peers’ fraud and abuse to carriers. Physician organizations could give more political support to utilization review activities of peer review organizations and carriers, and perhaps even revise their current views on additional policy options to control costs, since they would be sharing responsibility for cost containment with beneficiaries and taxpayers.26

An important part of an expenditure target policy would be opportunities for individual physicians to opt out of the areawide target by joining a smaller group of physicians that is placed at risk for its practice decisions. Such opportunities could include both those currently existing for health maintenance organization (HMO) risk contracts with Medicare and new ones involving looser organizations such as preferred provider organizations (PPOs).

The key argument in favor of the expenditure target option is that it emphasizes physician-directed attempts to reduce costs through reducing inappropriate services. To the degree that physicians are successful in this endeavor, it would appear to be more acceptable to most affected parties than the apparent alternative of reductions in payment rates. Arguments against expenditure targets are that (1) they would be set too low (require a larger reduction in utilization than physicians can bring about in a fee-for-service context) to achieve large budget savings and (2) physicians would fail in collective attempts to respond to the incentives and the result would be sharp reductions in fees—reductions substantial enough to affect access for beneficiaries.

Options For The 1990 Budget

Former President Reagan’s budget proposed reductions of $3.5 billion in Medicare for fiscal year 1990, of which $0.8 billion would be in physician payment.27 If Congress decides to make substantial reductions in physician payment, it is likely to find that the major policies discussed above cannot be implemented soon enough to provide large budget savings for fiscal year 1990.

While a Medicare fee schedule is not envisioned as a budget policy, its conversion factor could be set to reduce payments to physicians. But implementation before 1991 is unlikely. Increased support for effectiveness research and practice guidelines could not be used as a near-term budget policy because (1) the supported activities will take time to develop and grow before they can affect practice in a substantial way, and (2) it will be difficult to link projected activities with likely budget
impacts. Expenditure targets could be implemented as early as 1990, but setting the targets to produce large budget savings in the first year could be problematic. The infrastructure by which physicians could respond constructively to expenditure targets will take time to build, and placing heavy demands on it before it is ready could jeopardize the long-term potential of this option. Expenditure targets should be viewed more as a medium-term budget option than a short-term one, even if the policy were implemented soon.

Policy options to reduce the 1990 budget should be steps that move the program in the longer-term policy directions discussed above, or at least that do not increase the difficulty of pursuing them. For example, the overvalued procedures and primary care provisions of the 1987 budget reconciliation legislation moved relative payments in the direction projected for a fee schedule. The Reagan budget has followed this course by proposing additional reductions for overvalued procedures, a reduction in payments for radiology and anesthesiology, and increases for primary care. Some in Congress have contemplated using the results to date from the Hsiao study to identify additional overvalued procedures. In addition, for high-volume services, prevailing charge screens in those localities that are far in excess of the national mean could be reduced.

A key political issue will be whether these short-term budget policies increase or decrease the likelihood of enacting a fee schedule during this year. Substantial payment adjustments prior to a fee schedule could diminish support for a fee schedule by some, as a portion of its goal of rationalizing the payment structure would already have been accomplished. If such developments were to occur, the federal government could lose credibility for having pursued the fee schedule route and using the data produced only to reduce payments for selected services and areas.

**Conclusion**

Over the next two years, Congress will choose whether to accelerate the policy changes that it has put into effect since 1984. The policy direction on relative payments in Medicare is very clear. Thus far, payment reductions that are needed to meet budget objectives have been concentrated on those procedures and geographic areas thought to have charges that are high relative to costs. A continuation of this policy would involve combining increases for selected undervalued services with additional reductions for overvalued services and applying the policy to a greater number of services. A fee schedule would involve a more comprehensive approach to realigning relative payments. To date,
the general policy direction has enjoyed substantial consensus.

Discussions regarding policies concerning assignment have been much more contentious. In the absence of consensus, the future course is more difficult to predict. Medicare now encourages assignment through the participating physician category and limits the size of balance bills through MAAC limits and through provisions applying to services of radiologists and services for which prevailing charges have been reduced. Major decisions concerning assignment are likely because inaction does not guarantee continuation of the status quo. If MAAC limits continue in their present form, they will constitute an increasingly stringent limit on balance bills over time. Either a fee schedule or simply an extension of overvalued procedures policy to more procedures would require a revision of MAAC rules because the 1984 base of actual charges will be less relevant.

Policies designed to deal with rapidly rising volume of physician services may constitute some of the most difficult decisions. Uncertainty concerning the effectiveness of various options is very high. Few are confident that the solutions that they advocate will work. Emphasis on pursuing multiple approaches is warranted.

The quandary over how to slow rising volume has led many to begin to think beyond Medicare policies. Many who advocate the competitive approach suspect that further progress in enrolling the privately insured in competitive health plans may be needed before they play a much larger role in Medicare. All-payer policies for physician services come up in discussions with increasing frequency. Some have a Canadian model in mind—physicians working collectively to deliver care under a budget constraint. Others see all-payer policies as a more serious spur to doctors to opt out of unmanaged fee-for-service by affiliating with competitive health plans. Without a more comprehensive approach to financing health care, whatever the mix of competitive and regulatory elements, increasing costs of care may not be controlled in a manner that is broadly acceptable.

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NOTES

1. Entitlement programs specify benefits for individuals. In contrast to appropriated programs, for which spending is determined annually through legislation or appropriations, spending for entitlement programs depends on factors such as how many individuals meet the eligibility requirements.

2. In a program such as Medicare, where spending under current law is projected to increase rapidly, budget reductions still allow for substantial increases in spending.


5. See Physician Payment Review Commission, 1988 Annual Report to Congress (Washington, D.C.: PPRC, 31 March 1988), Appendix 1, for a description of the methods by which these procedures were identified.

6. Assignment means that the beneficiary assigns his or her right to payment by Medicare to the physician. To be paid directly by Medicare, the physician agrees not to collect from the patient any more than applicable deductibles and coinsurance.

7. Many of the policy changes described earlier were consistent with the recommendations of the commission. These: include reductions in prevailing charges for overvalued procedures, increases in payment for primary care services, and a payment increment for services delivered in physician shortage areas.


9. W.C. Hsiao et al., A National Study of Resource-Based Relative Values for Physician Services: Final Report, HCFA contract no. 17-C98795-03 (27 September 1988), Tables 64, 90, 91. Note that the time and effort measured for gallbladder surgery includes all services by the surgeon while the patient is in the hospital but does not include postoperative office visits.


11. In the United States, research by Thomas Rice and Nelda McCall on the Colorado Medicare carrier’s experience in consolidating eight charge localities into a single one is one of the few examples. T. Rice and N. McCall, “Changes in Medicare Reimbursement in Colorado: Impact on Physicians’ Behavior,” Health Care Financing Review (June 1982): 67–86. Canada holds great promise for such research as each province has independently changed its relative value scale over time, thus providing both cross-sectional and time series variation. A research group at McMaster University is beginning one such project (see J. Lomas et al., “Paying Physicians in Canada: Minding Our Ps and Qs,” in this volume of Health Affairs).

12. Hsiao et al., “Results and Policy Implications of the RBRVS Study.” For a much more detailed description of the methods and results, see the nine articles published by Hsiao and his colleagues in Journal of the American Medical Association (28 October 1988).

13. The Hsiao estimate is from W.C. Hsiao et al., “Results, Potential Effects, and Implementation Issues of the Resource-Based Relative Value Scale,” Journal of the American Medical Association (28 October 1988): 2434. The change in the formulation of practice costs is not the only difference between the PPRC and Hsiao scales, but it is by far the most important. Other differences include the PPRC’s having taken account of changes in payment rates between 1986 and 1988 and extrapolation to a much larger...
number of services. Additional revisions are planned by the PPRC over the next few months.

14. A special factor for malpractice premiums would be included, which would vary by specialty or by risk class. The malpractice component would probably apply to different geographic units than other components of practice costs.


17. Some organizations, such as the American Academy of Family Physicians, have advocated uniform national fees.


21. Since the initial payment rates were set at 97 percent of the fee schedule amount, the limit on balance bills is actually 18 percent of the amount approved by Medicare.


26. One example is pending legislation on physicians’ ownership interests in facilities to which they refer patients. While many physician organizations have urged their members to avoid such arrangements on ethical grounds, they have not supported legislation to prohibit specific practices. They might take a different position in the context of expenditure targets.

27. This article was completed before the Bush budget was released.