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Prologue: For the most part, efforts to reform the way Medicare pays physicians have focused on administrative fee-setting approaches: fee schedules, adjustments of fees to reflect geographic variation in costs of care, rebasing the Medicare Economic Index, and other strategies. The rationale for administered pricing centers on the pervasive view that to continue the current style of paying physicians under Medicare will merely drive prices higher. One voice in the crowd, however, has suggested an alternative approach to meeting the goals of physician payment reform: competitive bidding. In this article, economist Jeff McCombs advocates retaining market-driven physician payment; his proposal draws heavily on the competitive bidding model used in setting payments for durable medical equipment and outpatient clinical laboratories under Medicare. His approach keeps the task of setting prices in the hands of providers, who, he contends, know best what it costs to provide health care services. While similar to the “customary, prevailing, and reasonable” charge scheme that is currently under siege, his proposal carries with it the prospect of economic sanctions for providers whose prices fail to fall in line with those of their peers. The proposal also addresses the issue of equity; because each locality would conduct its own bidding, physician fees would reflect the nature of the local market more than a nationally set fee schedule would. McCombs received his doctorate in economics, with an emphasis on health, from the University of California, San Diego. He spent two years at The Johns Hopkins University School of Hygiene and Public Health and over three years at the Health Care Financing Administration (HCFA) Office of Research and Demonstrations. While at HCFA, he was directly involved with efforts to design competitive bidding systems for durable medical equipment and outpatient clinical laboratory tests for Medicare. In July 1987, McCombs joined the faculty at the University of Southern California’s School of Pharmacy as an assistant professor.
In 1986, Congress created the Physician Payment Review Commission (PPRC) to advise Congress and the Health Care Financing Administration (HCFA) on physician payment reform under Medicare. The PPRC enumerated eight goals to guide the development of alternative physician payment systems in its 1987 annual report: the payment systems should maintain or improve access to and quality of care, provide adequate financial protection for the beneficiary, increase the equity of payments across physicians, slow the growth in expenditures, be understandable and provide for orderly and coherent change, and accommodate plurality in the organizational structure of medical practice. This latter goal specifically states that fee-for-service medicine should not be abandoned.

To meet these goals, the PPRC recommended in its 1988 annual report a system of administered fees based on a resource-based relative value scale (RBRVS), such as that developed by economist William Hsiao at Harvard University. In this article, I propose an alternative approach to setting physician fees under Medicare, which uses price competition among providers rather than regulation to achieve the goals set forth by the commission. This price competition would be based on an RBRVS but would allow for direct pricing of the most common procedures. The competitive bidding would be conducted within specialties, thus eliminating the need to develop interspecialty conversion factors. This article presents the basic structure of the proposed approach; however, some of the detail required for implementation is omitted for brevity.

**Administered Pricing Versus Competitive Systems**

**Administered pricing.** Physician fee schedules set administratively must overcome significant obstacles if they are to meet the PPRC goals. These obstacles can be summarized in terms of an asymmetry of information. Physicians, and physicians alone, have access to data on the true economic cost of providing services, including the individual physician’s valuation of time. Time is the single most important resource in the production of physician services, representing an average of 58 percent of the resource cost. The PPRC, HCFA, and Congress have access to historical data on prevailing charges that do not reflect the economic cost of providing care. Any reform of the Medicare physician payment system that bases fees on historical prevailing charge data will only institutionalize the inequities of the past. Therefore, an administered pricing system must attempt to estimate the cost of providing services if the system is to contain the cost of physician services. Further, the system must reflect local or regional differences in the cost of providing care, especially the
cost of physician time, if it is to achieve the goal of payment equity across physicians.

Collecting data on the true economic cost of providing care will be intrusive, complicated, and expensive. The cost of this effort will be increased further if the data collected are to reflect local or regional differences. Further, basing payment rates on these data may affect their validity. Physicians will face economic incentives to either bias the data provided or adjust their operations to maximize reimbursements much as hospitals did under the Medicare cost-based payment system.

The methodological difficulties of estimating the value of physician time are evident in the methodologies used to estimate the interspecialty conversion factors for the Harvard RBRVS. The methodologies required to set fees based on local practice costs (such as rent, labor, insurance, transportation, utilities, and so on) and the estimated value of physician time in the local market will be even more complicated and controversial. For example, conventional wisdom holds that physicians’ practice location decisions are affected by factors such as the availability of medical resources, or the cultural activities of a New York, or the overall attractiveness of a San Diego. Does this mean that physicians in New York or San Diego should be paid less per hour than comparable physicians in less “attractive” locations? If so, how much less? Physicians in these areas could counter that they face higher costs of living, especially real estate costs. The regional equity issues inherent in administered pricing systems may paralyze any effort to institute true reform.⁷

Clearly, administered pricing systems for physician fees will fail to meet the goals of the PPRC. Administered fees will not necessarily improve the equity of payments, either across specialties or across geographic regions. Administered pricing systems will not be understandable or provide for orderly and coherent change. Timely adjustments for changes in technology or practice costs will be impossible since physicians must first experience these changes before data can be collected and manipulated by the bureaucracy. Administrative costs would be exceedingly high, and the collection of required practice costs data would constitute a major intrusion into the physician’s practice. The methodologies used to transform these data into a fee schedule will take “voodoo economics” to new heights. It is time to step back from the bureaucratic swamp of administered fee schedules and chart a new course.⁸

Price competition. Purchasers of goods and services in price-competitive markets do not have to concern themselves with production costs because competition forces price to approximate average cost. Market conditions that allow providers to set price above average cost cannot persist in the long run since the resulting excess profits will attract
additional providers to the market. This increased competition bids down price to average cost, thus eliminating the incentives for further market entry. Therefore, in a competitive market, decisions on the ebb and flow of resources into the market and the adjustment of prices to changes in production costs are made by providers who have immediate access to the required data. Government intervention in the market is limited to maintaining orderly competition and protecting consumers from fraud and other abuses.

For price competition to be effective, purchasers must be aware of price differentials across providers, and market sanctions must be imposed on high-priced providers in the form of lost sales volume. Can price competition be created in the market for physician services? Can the major purchasers of physician services, such as Medicare, use their market power to force physician fees to approximate the economic cost of providing services, including the economic price of physician time? Can these large purchasers create incentives for their beneficiaries to gravitate to lower-priced providers while maintaining both adequate access to high-quality care and adequate financial protection against the cost of care? If the answer to all of these questions is “yes,” then such a pricing system should provide equity across physicians and slow the rate of inflation in fees to the rate of inflation in the cost of providing care.

A Proposal

The physician services pricing system I propose is patterned after the old reasonable charge methodology, but makes two fundamental changes in that system. First, individual physicians will provide Medicare with a list of prospective fees at which they are willing to treat Medicare beneficiaries on an assigned basis. Physicians who fail to participate in this process, in effect, withdraw voluntarily from the Medicare program. These fees will remain in effect for a set time period (such as one year), after which a new prospective fee schedule will be submitted by physicians for the following period. The physician’s prospective fee schedule will be compared to the prospective fees quoted by the physician’s peers in the local area and a reasonable fee determination made following published criteria, as is the case in the old system. However, a financial sanction will be imposed on all physicians whose prospective fee schedule exceeds the standard of reasonableness set by their peers. This sanction, which will take the form of fee discounts, is the key that creates effective price competition within the local physician peer group. Physicians must balance their desire for higher fees against the increasing probability that their bid will exceed the price quotes of their peers, resulting in the
discount fee sanction. The major components of this approach are outlined below.

**A product definition schema.** Physicians typically provide a wide range of services as specified in HCFA’s Common Procedure Coding System (HCPCS). It will be overly burdensome to require that physicians submit prospective prices for each HCPCS procedure. Therefore, a relative value scale (RVS) across physician services must be specified and bids requested for the RVS conversion factor. Most RVSs, including the resource-based RVS developed for HCFA by Harvard University, are a collection of independent specialty-specific scales linked by internal conversion factors. Most physicians typically restrict their practices to services included on a limited number of specialty-specific RVSs. Therefore, physicians should be allowed to submit RVS conversion factor quotes for those specialties desired. A physician who submits an RVS quote for more than one specialty competes in each market independently and may achieve preferred provider status in one or more specialties. Physicians who do not bid on a specialty RVS generally will be precluded from billing services for that specialty. However, some limited cross-specialty billing can be allowed by preferred providers who occasionally perform specialized services outside their selected specialty. For example, cross-specialty billings could be limited to a fixed percentage of the preferred providers’ total Medicare billing for the year (such as 10 percent).9

The Harvard RBRVS can be used as the product definition schema; however, the exact specification of the procedures included on each specialty RVS is negotiable. The purpose of the proposed system is to set price once the specialty RVSs are established. The separate specialty competition does eliminate one of the most controversial aspects of any all-inclusive RVS: the internal conversion factors across specialties. These relative factors are set implicitly once the competitive specialty-specific fee schedules are established. Furthermore, specialties in relatively high supply in the local market may experience the most aggressive competition, thus creating incentives for the redistribution of specialists to less competitive (underserved?) practice locations.

**Determining the “cutoff” price for preferred providers.** A key to this proposal is the methodology used to determine a reasonable “cutoff” price for the selection of preferred providers. The system proposed here adheres to the established principle that a reasonable price can be determined only by the physicians in the local specialty peer group. Under the old system, reasonable charges were capped at the local prevailing charge, which was typically set at the seventy-fifth percentile of the distribution of historical customary charges. However, a fixed percentile
criterion for establishing the cutoff (prevailing) RVS price would impose financial sanctions on a fixed proportion of physicians in the specialty peer group, even if the distribution of RVS prices is tightly clustered.

The approach here proposes to use a “percentile plus percent” methodology, which specifies a percentile of the distribution of RVS prices (such as fiftieth percentile or median) to which a fixed percentage (such as 5 percent) is added to determine the cutoff price for selecting preferred providers. For example, a median RVS price of $100 would result in a cutoff RVS price of $105 using the median plus 5 percent rule. All physicians whose RVS conversion factor quote is $105 or less would be awarded preferred provider status. If the distribution of RVS prices is tightly clustered around the median, then a high proportion of physicians in the local specialty peer group would achieve preferred provider status. Regardless, the median plus 5 percent rule will assure that over half of all physicians will achieve preferred provider status.

In the long run, the distribution of prospective RVS prices may become tightly clustered as the competitive cutoff price is revealed through repeated annual rounds of bidding. While the cutoff price may become predictable, based on last year’s price, changes in market conditions, and inflation in practice costs, the individual physician will be powerless to inflate this price artificially. An individual physician cannot increase the median of the distribution of prospective RVS prices by increasing his or her RVS conversion factor quote. Furthermore, such a unilateral strategy risks exceeding the cutoff price established by the physician’s specialty peer group, thus resulting in financial sanctions.

The Medicare fee schedule for preferred providers. There are essentially only two options for setting the fees that Medicare will pay preferred providers once the cutoff price is established. The first, known as the actual price system, would pay preferred providers based on their actual quoted RVS conversion factor. The second, known as the competitive price system, would pay all preferred providers a common fee schedule determined by the cutoff price. The latter appears on the surface to be more expensive for the Medicare program since it pays many preferred providers more than their RVS price quotes. This, in fact, may not be the case. Under an actual price system, physicians may inflate their RVS quotes above their “best price,” balancing the prospect of higher fees against the increased risk of exceeding the cutoff price. Under the competitive price approach, an inflated price quote only increases the risk of failure since all preferred providers receive the cutoff price. Therefore, physicians are led to bid their “best price” to maximize the probability of success, thus lowering the entire distribution of quotes. A search of the economics literature on the relative merits of the two
systems was unable to predict which system would be less costly to the Medicare program.\textsuperscript{10}

Other important considerations make the competitive price system preferable to the actual price system. First, a single specialty-specific fee schedule for preferred providers is more equitable and understandable for physicians and beneficiaries, and will be much easier to administer than physician-specific fee schedules. Second, the beneficiary’s out-of-pocket cost is defined more clearly under the competitive pricing system, which will facilitate the selection of lower-priced providers by beneficiaries. But more importantly, the single fee schedule provides an easy method for structuring the financial sanctions (discounts) imposed on nonpreferred providers, such that these physicians are provided with the maximum opportunity to continue to provide services to Medicare beneficiaries. I discuss these issues in the following section.

\textbf{Payments to nonpreferred providers.} It is absolutely essential that sanctions be imposed on physicians whose prospective RVS quotes exceed those quoted by the majority of their peers. Without sanctions, there is no incentive for physicians to quote their “best price” to the Medicare program. The most severe sanction would be to exclude high-priced physicians from participation in Medicare. Exclusion is neither necessary nor appropriate. First, exclusion denies access by Medicare beneficiaries to these physicians, which is inconsistent with the philosophy inherent in the original reasonable charge system under which beneficiaries who used high-priced providers simply paid higher out-of-pocket costs. Second, Medicare may be a major source of patients for the physician; therefore, exclusion from the program, even for a year, could affect the physician’s practice adversely in the long run. Finally, exclusion is particularly unjust for physicians whose quoted RVS price was close to the cutoff price for preferred providers. Equity dictates that the sanctions imposed under the proposed system reflect the level of the prices quoted by nonpreferred providers.

The approach proposed here would pay nonpreferred providers on a sliding scale that is tied to the differential between the cutoff price and the physician’s RVS conversion factor quote. For example, a physician whose RVS price exceeds the cutoff price by 5 percent would receive a 5 percent discount off the Medicare fees paid to preferred providers. The maximum discount could be capped, say, at 20 percent, such that beneficiaries who use very high-priced physicians receive at least 80 percent of the Medicare payments due under the fee schedule as reimbursement toward their unassigned claims. Nonpreferred providers must decide either to compete with preferred providers on the basis of equal patient out-of-pocket costs and accept lower total reimbursements,
or to risk losing patients by collecting the difference between their higher quoted price and Medicare’s reduced payment (known as balance billing).

A possible refinement. One of the major challenges in constructing an RVS, even within a specific specialty, is the relative evaluation of physician time spent in activities that require different skill levels or that impose different indirect cost on the physician, such as stress or risk of malpractice. In the system described above, the relative prices of all procedures are fixed, and the physician is required to quote a price only on the RVS conversion factor. It may be useful to implement a mixed system under which individual fee quotes are solicited for the common procedures and an RVS is specified for less frequently billed procedures. Under a mixed system, the relative fees for the majority of services billed by a physician would not be fixed by the RVS, but would be determined by the physician’s peer group, who have access to the data on the true cost of providing these services.

Under the mixed-system approach, the comparison of price quotes across physicians requires that the physician’s list of prospective prices be collapsed into a “market basket price” that reflects the inherent cost to Medicare of purchasing services from each physician. This is accomplished by calculating a weighted average price for each physician using weights based on historical Medicare billing frequencies. For example, if a routine office visit for primary care physicians constitutes 25 percent of all Medicare services billed by this specialty peer group, then the weight applied to the quoted routine office visit fee is .25. The weight applied to the RVS conversion factor quote would be determined by the relative frequency of billings from the entire list of procedures covered by the RVS conversion factor. The market basket price then is used to select preferred providers and to calculate the Medicare fees paid to preferred providers.

Implications

If one accepts the assumption that Medicare payments to fee-for-service physicians will not return to the halcyon days of usual, customary, and reasonable charges, then the proposed system compares favorably to a regulated or administered pricing system on the eight criteria set forth by the PPRC. In summary, I present the relative merits and disadvantages of these two options on each criteria.

Access to care. On the surface, the competitive approach proposed here appears to restrict access to something over half of all physicians based on the “median plus 5 percent” cutoff price. This is not necessarily
the case. First, competition and experience could narrow the distribution of price quotes over time, which would increase the proportion of physicians achieving preferred provider status. This regression to the median can occur in a local market in which physicians face similar practice costs. Furthermore, the major input to physician services is their time. Competition may force high-priced physicians to adjust their time price toward the median of their local peer group to achieve preferred provider status.

Second, the level of sanction for those physicians close to the cutoff price may be quite modest (for example, 1–10 percent). These physicians may choose to compete by absorbing the discount and charging the patient the same out-of-pocket cost as preferred providers. Third, lower-cost providers will receive payments above their asking price under the competitive pricing approach. The availability of these resources could improve access for the poor, especially if the lower-cost providers are located in poorer, underserved areas and these providers market to poorer patients by forgiving patient coinsurance liabilities on a case-by-case basis.

Administered fee schedules do not necessarily guarantee better access than the proposed approach. Physician participation will depend on the level of the fee schedule, on its equity across physicians and specialties, and on the timeliness of adjustments to reflect changing conditions. Administered fee schedules perform poorly on several of these dimensions. If Medicare attempts to reduce fees below current prevailing rates, then the beneficiary will be subjected to an unknown risk that physicians will choose not to participate or refuse assignment at the fee schedule price. State Medicaid programs have experienced difficulties with physician participation under administered fee schedules.

**Quality of care.** It will be argued that either an administered fee schedule or the proposed pricing system will adversely affect the quality of care as price is reduced. However, Uwe Reinhardt has suggested that the connection between the quality of care and the amount of money that society transfers to the providers of care may be tenuous at best. This may be particularly true for physician services for which the major cost to the provider is the provider’s own time.

The proposed system may be marginally better than an administered pricing system in several areas related to quality. First, a mixed system, in which the most common procedures are included explicitly in the bidding process, will adjust relative prices to reflect economic cost, thus eliminating any imbalances in economic incentives that may influence the physician’s treatment decision. Second, specialty-specific bidding will adjust relative fee schedules across specialties to reflect physician supply,
thus creating incentives for new physicians to select specialties in relatively short supply and to locate in underserved markets. Finally, competition at the local level may create incentives for physicians to relocate to underserved areas within the market.

Financial protection. Medicare beneficiaries who use nonpreferred providers are at risk for higher out-of-pocket cost. This is an accepted principle even under the reasonable charge system; however, under the proposed approach, the beneficiary also will be at risk for the fee discount assessed against nonpreferred providers. Other provisions may improve financial protection under the proposed approach. First, preferred providers have agreed to accept assignment, and the beneficiary’s out-of-pocket cost will be set prospectively. Under an administered fee schedule, the patient will not necessarily enjoy these protections, since physicians could continue to accept assignment case by case. Second, the postbidding competition between preferred and nonpreferred providers may force the latter into accepting assignment and charging the beneficiary a competitive out-of-pocket price;

Equity among physicians. All preferred providers in each specialty will receive a common fee schedule, determined by the majority of their peers under competitive conditions. The relative fee schedules across specialties will reflect the relative supply of physicians in each local specialty market. Local fee schedules will reflect the costs of living and the “attractiveness” of the local market area relative to other regions of the country. Fees will be updated annually to reflect changes in the local medical market. Absolutely none of these benefits is available under administered prices.

Reduction in the-growth of expenditures. The proposed approach has the potential to reduce current fee levels significantly and restrict the inflation of fees to increases in the cost of providing services. In 1985, the average reduction in current charges for physician services due to the Medicare reasonable charge determination process was 26.2 percent; however, roughly 60 percent of all Medicare claims for physician services were paid on an assigned basis. Preferred provider organizations (PPOs) have been found to enjoy average physician fee discounts of between 9 and 15 percent, having brought to the negotiations a far less significant market share than the Medicare program. Finally, the radical shifts in revenues that have been projected should the Harvard RBRVS be implemented clearly indicate that a wide disparity may exist in the implicit Medicare price of physician time across specialties. These data all indicate that physicians may be willing to accept much lower fees if subjected to the competitive pressures of the free market.

Any significant reduction in fees under an administered pricing system
would be exceedingly difficult for Medicare to implement because of the political outcry of the physician community. Even the reallocation of fixed resources among specialties based on an RBRVS will be vulnerable because of data and methodological limitations. Developing congressional support for the reallocation of resources based on methodologies that adjust the value of physician time across geographic regions will be difficult. However, in a competitive system, government does not have to address these issues. Physicians themselves will reveal their individual time valuations in their fee bids, adjusting for regional preferences, the local supply of specialists, and specialty-specific attributes of practice, such as human capital investment and stress.

It will be difficult for physicians to collude tacitly for the purpose of artificially inflating the fee schedule. A unilateral increase in bid price above the true cost of providing services will not increase physician fees. The cutoff price is tied to the median bid, and all preferred providers receive a common fee schedule based on the cutoff price. However, a unilateral increase in bid price above true cost will increase the physician’s risk of exceeding the cutoff price, thus incurring financial sanctions. Therefore, the individual physician has no incentive to bid above the true cost of providing care, including the cost of time.

This is not to say that physicians cannot anticipate the rate of increase in the fee schedule over time. Competition forces fees to be set equal to costs; therefore, the rate of inflation in bid prices will be tied to the observable rate of increase in practice costs and other factors, such as technological change. Competition may force high-priced physicians to adjust their own time price toward the time price bid by the majority of their peers. This “controlled freedom” constitutes the real strength of the proposed approach. Physicians who have access to the data on the true cost of providing services set fees in an environment that applies sanctions on high-priced providers. Because of the data provided to bidders on the time price of their peers and the predictability of the rate of increase in other practice costs, nearly all physicians may be able to submit bids within 5 percent of the median bid, thus extending preferred provider status to nearly all physicians in the market.

Physicians may have the ability to offset reductions in fees by increasing intensity and utilization. Competitive bidding does not resolve this issue, and more research is needed on how best to control these components of total costs.

Understandability. Paying physicians for over 7,000 different services, differentiated by specialty and locality, is necessarily a complex undertaking. Both the proposed approach and an administered fee schedule do not simplify this task. Physicians and beneficiaries will have access to the
fee schedule under both systems; however, under the proposed approach, the beneficiary also will know which physicians must accept assignment (preferred providers) and their out-of-pocket liabilities for each procedure. Furthermore, beneficiaries can easily assess the magnitude of any additional financial risk associated with the selection of a nonpreferred provider. For example, if the beneficiary selects a nonpreferred provider whose bid price exceeded the cutoff price by 5 percent, then the beneficiary is at risk for the 5 percent discount assessed in the Medicare payment levels and the 5 percent differential between the bid price and the cutoff price.

The process of setting fees under the proposed approach is relatively understandable in comparison to the difficulties inherent in approximating competitive fees under an administered fee schedule. First, the process of bidding is relatively straightforward, requiring only that the physician determine the specialties in which to compete and to submit an RVS conversion factor quote, or a relatively short list of additional procedure-specific prices under a mixed system. Second, this process is much more understandable than the bureaucratic manipulation of questionable data deep in the bowels of HCFA. Finally, competitively set fees will enjoy much wider acceptance by the public and the Medicare beneficiary as being inherently reasonable than bureaucratically or politically set fees. This may be very important since today's taxpayer appears to be reluctant to fund improvements in medical care programs, possibly because of the growing concern that increased public expenditures are going into the pockets of providers rather than to purchase additional services.

Orderly change. Undoubtedly, implementation of the proposed system could prove to be a severe shock to the present medical care system, if not to the personal finances of many physicians. An administered pricing system with phased-in reductions in fees or a leveling off of fee inflation would be more benign. However, over time, the relative advantage moves to the competitive approach, which allows the level of fees to adjust annually to changes in the cost of providing services as experienced by the physicians in the local market. The administered pricing system will be years behind in calculating adjustments that ultimately will be filtered through the political process before implementation.

Both systems will depend on some form of RVS, which will require periodic updating. This process will be simplified under the proposed system because the intraspecialty conversion factors are set competitively. The implementation of a mixed system will submit the most common procedures to competitive pricing, thus automatically adjusting their relative prices and reducing the scope of the RVS.

Pluralism. Fee-for-service medicine is under competitive pressure from
health maintenance organizations (HMOs) and competitive medical plans such as PPOs. This pressure is due in part to the increasing cost of fee-for-service practice. Medicare cannot survive long as the last bastion of unrestrained fee-for-service medicine and is searching for ways to reduce expenditures. Administered fee schedules will be difficult to implement and maintain because of methodological and data shortfalls. These limitations will make it difficult to reach consensus on the hard choices concerning reductions in fee levels and adjustments in relative fees across specialties and localities. The proposed system may provide some hope that fee-for-service medicine can survive in a political environment that is becoming less willing to finance the style of practice, and the lifestyle, to which physicians have become accustomed.

Implementation strategy. The problem of developing pricing systems that both control inflation and provide equitable payments for Medicare providers is not limited solely to physician services. Other outpatient (Part B) services, prospective payments to hospitals, and the premiums paid to enroll Medicare beneficiaries in alternative practice arrangements (HMOs, PPOs) all require pricing determinations. HCFA and Congress have already instituted administered pricing systems for Medicare’s prospective payment system (PPS), HMOs under the Tax Equity and Fiscal Responsibility Act (TEFRA), and outpatient clinical laboratory services.

Given the severe limitations of administered pricing systems, it is essential that HCFA design and implement demonstration projects to test competitive alternatives. While payment for physician services is the second largest component of Medicare expenditures, it may be prudent to begin this research on a smaller piece of the Medicare pie. HCFA has developed similar pricing systems for durable medical equipment and clinical laboratory services to implement as demonstration projects. If implemented, these projects could provide considerable information concerning the further development of the concepts presented here. Unfortunately, HCFA has been unwilling or unable to overcome the strong political opposition by these provider communities to any proposal that would remove their historical protection from price competition. In the long run, such opposition to competitive reform of the Medicare pricing systems will result in an expansion of administered fee schedules to a broader array of providers.

Most of the competitive bidding concepts applied in this article to physician payment reform were developed originally for laboratory tests and durable medical equipment. This collaborative effort included analysts in the Office of Research and Demonstrations of the Health Care Financing Administration (HCFA), Abt Associates, and their outside consultants. This team included the author and Paul Ginyi from HCFA; Stephen Bell, Larry Orr, Stephen Mennemeyer, and Kevin
Marvelle from Abt; Jon Christianson from the University of Minnesota; and Richard Engelbrecht-Wiggans from the University of Illinois. I also acknowledge the contributions of Michael O’Leary, Michael Nichol, David Sclar, and an anonymous reviewer for their insightful comments.

NOTES


3. Implementation of the Harvard resource-based relative value scale (RBRVS) for Medicare physician payments holding constant total expenditures would result in radical shifts in revenues between specialties. W. Hsiao et al., “Results and Policy Implications of the Resource-Based Relative Value Study,” The New England Journal of Medicine (29 September 1988): 881–888. This volatility will hamper the implementation of the Harvard RBRVS as the methodologies used to derive the interspecialty conversion factors are challenged through the political process.

4. The approach proposed here builds on two similar pricing systems developed by Abt Associates under contract with the Health Care Financing Administration (HCFA) for durable medical equipment and outpatient clinical laboratory services. A summary of these proposed demonstration projects and a general discussion of the issues of competitive pricing systems can be found in J.S. McCombs and J.B. Christianson, “Applying Competitive Bidding to Health Care,” Journal of Health Politics, Policy and Law (Winter 1987): 703–722.

5. S. Zuckerman, W.P. Welch, and G. Pope, The Development of an Interim Geographic Medicare Economic Index, final report to HCFA, prepared under the Brandeis Research Center cooperative agreement no. 18-C-98326-01 and the Center for Health Economics Research cooperative agreement no. 17-C-98758-03, December 1987.

6. Hsiao and colleagues found that the mean Medicare charge by procedure did not correspond well to the RBRVS within specialties in addition to the inequities across specialties discussed previously. Hsiao et al., “Estimating Physicians’ Work for an RBRVS.”

7. For an excellent example of the difficulties associated with locating or creating appropriate databases and developing economically sound methodologies for the implementation of an administered pricing system for physician services, see Zuckerman et al., The Development of an Interim Geographic Medicare Economic Index.

8. Walter McClure discussed the implementation of administered fee schedules by the Medicare program in a recent interview in Health Affairs. McClure’s “buy right” approach to reforming the health care market depends on the creation of incentives for patients to select efficient, high-quality providers of health care. The competitive pricing system proposed here addresses half of this equation by creating incentives for patients to select low-cost physicians. However, the proposed pricing system is silent on the issue of providing Medicare beneficiaries with data on quality. While the issues of pricing and providing information on quality are separable, the success of a competitive pricing system will depend on market sanctions for poor-quality care. J.K. Iglehart, “Competition and the Pursuit of Quality: A Conversation with Walter McClure,” Health Affairs (Spring 1988): 79–90.

9. The proposed system will not place any restrictions on the qualifications required to bid
on each specialty RVS, such as board certification. However, the medical profession may want to consider such restrictions in the light of quality assurance. It may be appropriate for HCFA to require that physicians have a history of billings within a specialty area as a prerequisite for bidding to avoid spurious bids by physicians. Physicians would be allowed to appeal these restrictions prior to bidding if they can demonstrate clearly that their future practice will in fact consist of services specified on the specialty RVS.


11. The competitive pricing systems designed by HCFA for durable medical equipment (DME) and outpatient clinical laboratory services specify lists of commonly purchased services for bidding. The list of DME is further divided into subsets of equipment, which allows DME dealers to compete by product group, recognizing that not all DME suppliers provide a full range of equipment.


15. Hsiao et al., “Results and Policy Implications of the RBRVS Study.”

16. The two HCFA demonstration projects on which this proposal is based have yet to be implemented. The laboratory services competitive bidding project has been stymied by amendments to legislation, which have imposed a series of one-year moratoria on the project. The legislation reforming Medicare payments for durable medical equipment specifically bans experimentation with competitive bidding.
