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The Spring 1989 issue of Health Affairs addressed the controversial area of physician payment reform. To some of the authors, the most important issue was determining the right price to be paid per service; to others, it was the quantity of services provided; and still others turned to other countries’ experiences in dealing with their own cost problems. It should be of little surprise that no consensus emerged among the authors, just as no such consensus has yet emerged in Congress or nationally on how we should reform physician payment.

One of the main impediments to enacting meaningful physician payment reform in the Medicare program is the fear that cost savings may come about at the expense of reduced access or quality. This theme was echoed by most of the authors and was the focus of James Sammons of the American Medical Association (AMA), in his Commentary entitled “Physician Payment Reform: Don’t Forget the Patient.” Sammons pointed out, quite correctly, that the original purpose of Medicare was to improve access to and quality of medical care for the elderly. He further stated, “Access to care will be jeopardized unless the new reimbursement system is designed to reflect the needs of the Medicare patient,” and concluded that “access to high-quality health care can only be guaranteed if physicians are allowed to determine their own fees.” The latter viewpoint is held by many outside of the AMA. For example, John Holahan and Stephen Zuckerman concluded that mandatory assignment constitutes an “unnecessary risk” to the patient, because it could lead to “severely restricted access” to physicians if the latter choose to limit the number of services provided to program beneficiaries.

In a fee-for-service system, the consequence of allowing physicians to freely choose either the price (P) or the quantity (Q) of services that they provide is that it is difficult, if not impossible, to control aggregate health care expenditures (E). Since $E = P \times Q$, E can be contained only when both...
P and Q are contained. In the Medicare program, physicians always choose their own Q, they choose P as well for nonassigned services. Although some might postulate that market forces can successfully regulate both determinants of expenditures, there is little evidence to support this view. Practically all studies of the effects of fee controls have shown that physicians increase Q when P is constrained; and that once price controls are removed, P rises back to the level it would have reached in their absence.6 Allowing physicians the flexibility to determine either P or Q, much less both of them, makes cost control very problematic.

The title of Sammons’ Commentary reminds us that we should not “forget the patient” when enacting physician payment reform, and he indicates that we will do just that if we dictate the Ps and Qs, because this will jeopardize access for the Medicare population. In this regard, he adopts what Victor Fuchs has labeled the “monotechnic” viewpoint, in which one “fails to recognize the multiplicity of human wants and the diversity of individual preferences.”7

I introduce the notion that a society that is concerned about the well-being of its elderly should wish to maximize not only access to care, but rather a broader measure of welfare. This measure of welfare should encompass two components, not just the one (access) implied by Sammons. The other factor is how much money the elderly have left after they pay all of their medical care expenses. Including this second item has crucial implications with respect to physician payment reform.

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**Medicare Part B Cost Inflation**

Allowing physicians to choose both P and Q has been largely responsible for the socially unacceptable rates of inflation that have plagued Medicare Part B since its inception. Originally, physicians as a whole could determine their own prices under the customary, prevailing, and reasonable (CPR) charge system that was adopted as part of the initial Medicare legislation. Not surprisingly, this system resulted in tremendous inflation in physician fees; consequently, Congress applied some brakes in the early 1970s when it enacted the Medicare Economic Index, which constrained the rate of increase in program fees per service. Since that time, expenditure inflation has not abated, but this is because of quantity, not price, inflation. Between 1975 and 1985, the total number of Part B services per Medicare beneficiary has doubled, from twelve to twenty four per year.8

It doesn’t take a sophisticated knowledge of accounting to know that a dollar of expenditure must be supported through a dollar of revenue. Until recently, Medicare Part B costs were paid largely through general
revenues, with only about one-quarter accounted for by the premiums paid by beneficiaries. This is no longer the case; the additional benefits brought about through the new Medicare catastrophic legislation are to be paid in full by Medicare beneficiaries. This change in financing—which in turn has resulted in the call by many to rescind the new benefits—has brought to the forefront the heavy financial burden of public and private health insurance premiums facing the elderly.

In 1988, the monthly Medicare Part B premium was $24.80, or $298 per year. This is projected to rise to $42.60, or $511 annually, by 1993, partly as a result of the four-dollar monthly premium increase, which helps finance the new benefits, but primarily because of anticipated expenditure inflation. These figures do not even include any of the liabilities associated with the controversial new supplement premium, which will raise the amount of income taxes paid by about 40 percent of the elderly, by as much as $800 per person per year in 1989 (for the most wealthy).

The monthly Medicare premiums have never been the only cost paid “up front” by the elderly. Most also own supplemental health insurance (that is, “Medigap”) policies. In spite of the enactment of the Medicare catastrophic legislation, which should have reduced Medigap policy premiums by expanding the domain of services covered by Medicare, these premiums are rising at startling rates. A typical policy was estimated to cost $542 per year during 1987. It has been reported that premiums rose by an average of 40 percent at the beginning of 1989, reflecting increased claims experiences during the previous two years. The annualized increases therefore were almost 20 percent. Had it not been for the new Medicare benefits, they would have risen by 10 to 15 percent more. If we make the conservative assumption that the rate of increase in premiums does not keep up quite so torrid a pace, but declines to 15 percent annually over the next four years, then a typical policy will cost $1,327 during 1993.

There are two other cost items paid by the elderly with Medigap policies: the extra costs associated with nonassigned claims and the costs of services not covered by Medicare. We have only sporadic data on the latter from occasional national surveys. There are data, however, on the liability posed by nonassigned claims: on average, they cost beneficiaries about $75 per year. Because assignment rates are increasing, it is unlikely that this cost will rise above its average 1988 level of $75 per Medicare beneficiary per year.

Adding these together leads to some sobering implications. Total costs of Part B premiums, Medigap policies, and unassigned claims averaged about $915 in 1988, but are expected to rise to $1,913 in 1993, and this does not even include the supplemental premium.
How much of a burden this represents can be gauged by comparing these costs to income. For the sake of argument, let us examine individuals (as opposed to married couples), as they are likely to be most vulnerable financially. The median income of elderly individuals was $7,731 in 1986. Assuming that a typical individual’s income rose by a total of 5.5 percent over the next two years, reflecting the Social Security cost-of-living adjustment over that period, such a person would have paid 11 percent of income ($915 of $8,156) toward these medical expenses in 1988. Furthermore, assume that income rises by 3.5 percent per year until 1993, which corresponds to the average cost-of-living adjustment between 1983 and 1988. In 1993, then the typical elderly person would pay 20 percent of income ($1,913 of $9,687) toward medical expenses, fully one-fifth of total purchasing power and nearly double current levels.

The figure for blacks would be even higher, 25 percent, reflecting their lower income levels. Furthermore, those with incomes lower than the average, but still above the Medicaid cutoff, also would pay a greater share of their income toward medical care. Imagine what these figures will look like if Health Care-Financing Administration (HCFA) actuaries are right and health care constitutes 15 percent of gross national product (GNP) by the year 2000.

Even if one makes much more conservative assumptions about the future inflation rates in Medigap premiums, and more generous estimates of future increases in Social Security income, the rise in the proportion of income that will have to be spent on medical care will still be substantial. For example, if Medigap premiums rise by 10 percent per year instead of 15 percent, and Social Security income rises by 6 percent annually rather than 3.5 percent, fully 16 percent of incomes will be spent on public and private health insurance premiums and nonassigned claims in 1993, compared to the 1988 figure of 11 percent.

How much of a problem these scenarios present depends on how one measures welfare. If we take the view that access to care by the elderly is the only determinant of welfare, then there is no problem at all. The elderly continue to enjoy nearly unlimited access. If, however, one views welfare in a broader context and asks about the ability to purchase not just medical care, but other necessities such as food and housing (not to mention amenities), then there is a very serious problem: the elderly have achieved access to medical care at the direct expense of losing the purchasing power to have access to everything else!

Although many reasons account for this state of affairs, I suspect that most of it has to do with allowing providers of care to control both prices
and quantities. In a fee-for-service system, physicians get more by doing more and charging more.

**Protecting Beneficiaries’ Well-Being**

Critics will point out that if the government puts the squeeze on physicians, the physicians simply will switch over to the non-Medicare market, thus harming access to medical services for Medicare beneficiaries. There are two responses. First, private insurers are unlikely to be put in a position where they are taking the brunt of switching. Insurers have been losing money for several years on their group insurance policies and can ill afford to become even more attractive targets by paying rates much higher than Medicare’s. It would seem prudent that they follow Medicare’s lead in the area of physician payment reform.

Second, and even more important, we must recognize that just because there may be costs in terms of an increased risk of reduced access to medical care, this does not imply that these costs are too high. It may be that, short of nationalizing our system, cost control will only come about by “just saying no,” even at the expense of jeopardizing current levels of access to medical care. It is noteworthy that there is a good deal of evidence to show that the extra services received by the well-insured, nonpoor (albeit, nonelderly) population do little to increase their health status.

Obviously, “meat ax” sorts of approaches that unilaterally reduce prices and quantities are less desirable than those that are carefully designed to institute incentives that will encourage providers to act in a socially desirable manner. Much thought should be put into aligning physician and societal incentives; a good example, in which physician payments would be made prospectively to the medical staffs of hospitals, was proposed by Pete Welch in the Spring 1989 issue of *Health Affairs*.

Although putting financial pressure on providers does pose a risk to medical care access, I believe that far greater benefits will accrue to beneficiaries if we finally can get hold of costs: these benefits will be in the form of increased welfare brought about through enhanced financial access to all nonmedical goods and services. Given the already large and increasing financial burden posed by health care costs, it is time for us to start thinking about taking a few sensible, calculated risks.
NOTES


2. It is noteworthy that the study by Blendon and Taylor implies that a consensus may be forming in the United States in favor of a nationalized health insurance system similar to that in Canada.


4. Ibid.


11. Ibid.


18. Welch, “Prospective Payment to Medical Staffs.”