In the Fall 1989 issue of Health Affairs, William Glaser of the New School for Social Research offered his perspective on physician payment reform in the United States. In that Commentary, entitled “The Politics of Paying American Physicians,” Glaser compared physician payment in this country to the way several European nations traditionally have approached the problem. His Commentary has sparked lively debate among interested parties: legislators, the Physician Payment Review Commission, the academic community, and organized medicine. The following Perspectives on physician payment offer the views of several of these parties. They appear in alphabetical order. To conclude this interchange, Glaser answers his critics.

Defending U.S. Physician Payment Reform

by Paul B. Ginsburg and Philip R. Lee

In his Commentary, “The Politics of Paying American Physicians” (Health Affairs, Fall 1989) William A. Glaser criticizes the developing reform in physician payment from various, often inconsistent, perspectives. If there is a basic theme, it is that American policymakers have not looked enough at the European experience in this area (and have not listened enough to his advice) and thus will not succeed.

But much of what Glaser says appears to reflect surprising ignorance not only of recent developments in health care policy in the United States but of the American political system. If he had paid closer attention to health policy in the United States, he would realize that in moving toward reform, we are taking the tough steps that he feels are necessary and we have drawn a great deal from the experience in Europe and Canada. ¹ Nevertheless, there will be important differences between the shape of reform in the United States and payment mechanisms in Europe and Canada that reflect differences in government structure and values of the populace.

Paul Ginsburg is executive director of the Physician Payment Review Commission (PPRC) in Washington, DC. Philip Lee is chairman of PPRC, and is director of the Institute for Health Policy Studies at the University of California, San Francisco.
Let us first summarize the direction of reform in the United States. In April 1989, the Physician Payment Review Commission (PPRC) reported to Congress with a comprehensive set of recommendations for Medicare physician payment reform. These include a Medicare fee schedule based on estimates of costs, uniform percentage limits on balance billing, expenditure targets, and federal support for effectiveness research and the development of practice guidelines. The recommendations have received strong support from the Bush administration and have been followed closely by those in Congress drafting legislation. In the final hours of its 1989 session, the 101st Congress passed the Omnibus Budget Reconciliation Act (OBRA) of 1989, which includes all of the above recommendations for physician payment reform.

**Fee schedule.** First, Medicare will determine payments to physicians on the basis of a fee schedule, with relative values of different services and multipliers for different geographic localities based on estimates of relative costs. The starting point for estimates of relative physician time and effort will be those from the resource-based relative value scale (RBRVS) under development by William C. Hsiao and his colleagues at Harvard University. Practice costs are incorporated into the relative value scale according to a formula developed by PPRC. The geographic multiplier will be based on one of the alternative geographic cost-of-practice indices developed by the Health Care Financing Administration (HCFA).

Glaser complains about delay in the implementation of the fee schedule to permit additional research by the Harvard team and others, but implementation has in fact already begun and will take a large step in 1990. Keener observers have noted that provisions of OBRA 1987, which specified a higher update for primary care than for other services and reductions in prevailing charge levels for thirteen families of procedures, were a significant initial step toward payment reform. OBRA 1989 specifies differential updates for primary care and other services, a reduction in conversion factors under the radiology fee schedule, and reductions in prevailing charges for thirty-six families of procedures (245 codes). These changes are all based on PPRC’s current estimates of relative values under the fee schedule and its judgments as to which estimates are accurate enough at this point to use in a transition. The additional research by Harvard, PPRC, and others will lead to refinements and extensions of the fee schedule down the road, not a delay in implementation.

Glaser calls for implementation of a fee schedule based on charges, with changes in relative values left for the future. He fails to recognize
that the motivation for payment reform is a more rational pattern of relative payment—not replacement of the reasonable charge method with a fee schedule. The current Medicare methodology has evolved over the years toward a *de facto* series of charge-based fee schedules at the locality level, as constraint on increases in prevailing charges has led to payment of most services at the prevailing charge screens.

**Limit on balance billing.** The second aspect of reform is replacement of the current maximum allowable actual charge (MAAC) limits with a uniform percentage limit on balance billing. Glaser laments that mandatory assignment was not part of PPRC’s proposal and has not received much consideration in Congress. But he neglects to mention the substantial increase in financial protection for beneficiaries to which the policy would lead. PPRC has estimated that a 20 percent limit would reduce aggregate balance billing by almost two-thirds. It is true that political feasibility of the package of payment reform proposals was a factor behind the lack of support for mandatory assignment by some PPRC members. However, the policy that did receive widespread support on the commission as part of the payment reform package was not at all a retreat from the issue, but rather one that will have a major impact.

**Expenditure targets.** The concept of basing fee updates on how spending growth compares to an expenditure target appears to have become embedded in the thinking of policymakers. OBRA 1989 includes such a policy, labeling it “Medicare volume performance standards.” The continued need to reduce the federal budget deficit will work to ensure that this linkage is maintained. Indeed, we would not be surprised if the medical profession comes to see expenditure targets not as a threat but as a basis for arguing for limiting budget-driven squeezes in fees (“expenditure growth was below the target, so we should get a full update”).

---

**The Role Of Physicians In Payment Reform**

One of Glaser’s main points is that the only way to implement a fee schedule is the way some European countries do—with formal negotiations between an organization of physicians and the government and with relative value decisions made in private by the physician organization. We agree that physicians must play an important role in developing and maintaining the fee schedule, but, having discussed these issues with Canadian colleagues and commissioned a comparative study on the fee schedule update process, we feel that mechanisms other than formal negotiations are likely to be more successful in the United States.\(^3\)

Formal negotiations pose serious problems, such as who would represent physicians, who would represent the government, and how other
parties with an interest—such as the beneficiaries and private payers—would be represented. Many physicians’ strongest professional allegiance is to their specialty society, and the larger specialties have gone quite far in setting up their own voice in Washington. Representation of the government would be problematic in that HCFA would have little authority to negotiate as long as Congress continues to make the major annual budgetary decisions itself. While Glaser sees great potential in recent federal experimentation with “negotiated rule making,” we see it only as one of many tools to assure that executive branch agencies incorporate the views of interested parties and build consensus.

Informal negotiation with physicians. The process requirements for which Glaser advocates formal negotiations can be met through a more informal process that is more in keeping with the way political decisions are made in the American context. Note first that the Harvard study was conducted with extensive support and encouragement by the American Medical Association and many specialty societies. The core of the study is interviews with physicians asking them to rate the “work” involved in different procedures. Thus, advice and guidance came from the leaders of organized medicine, and the core data came from the rank and file of practicing physicians. PPRC is now developing a process through which physicians can play a key advisory role in refinement of the relative values.

Second, lack of a formal mechanism for negotiations does not mean that medicine does not play a political role. Medical organizations nominate members of PPRC and are heard in various public and private forums by the commission. They also lobby the administration and Congress. The fact that Congress has enacted so many of PPRC’s recommendations is a reflection that the commission has succeeded in weighing the interests of the various physician organizations, organizations representing beneficiaries, and others, and has constructed viable compromises on key issues.

Third, the emphasis on research and analysis in the development of the fee schedule not only is critical in the American context, but is being viewed with increasing interest abroad. Both organized medicine and beneficiary groups want the changes in relative payments to be based on the best data available rather than the outcome of arm wrestling in private among only some of the affected parties. Both medical associations and government officials from nations with long-standing fee schedules have approached us to learn how research and analysis similar to that used to develop the fee schedule for Medicare can be incorporated into their process.

In conclusion, Glaser has identified some of the political requirements
of mechanisms to pay physicians but errs in seeing the standard European process as the only viable way to meet them. The emerging legislation for payment reform in the United States meets these requirements in ways more suited to the American structure of government and political traditions.

NOTES

1. Indeed, Glaser’s presentations before the Physician Payment Review Commission and discussions with us contributed to the commission’s taking a closer look at foreign payment mechanisms and traveling to a number of Canadian provinces. Glaser also increased our recognition of the importance of physician involvement in both the overall development and in the details of the payment system. We regret that Glaser does not perceive his constructive influence.
