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REFORM OF MEDICARE PAYMENTS TO PHYSICIANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

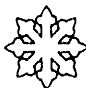
COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

DECEMBER 6, 1985



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REFORM OF MEDICARE PAYMENTS TO PHYSICIANS

FRIDAY, DECEMBER 6, 1985

U.S. SENATE,
COMMITTEE ON FINANCE, SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:15 a.m. in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Dole, Durenberger, Heinz, Baucus, and Boren.

[The press release announcing the hearing and a background paper by the Congressional Research Service on Physician Reimbursement under Medicare, and the opening statements of Senator Durenberger and Senator Dole follow:]

[Press Release No. 85-082, Wednesday, October 9, 1985]

SUBCOMMITTEE ON HEALTH SETS HEARING TO REVIEW POSSIBLE REFORM OF MEDICARE PAYMENTS TO PHYSICIANS

Ongoing studies and evaluations of possible changes in the Federal supplementary medical insurance program (Medicare Part B) payments for physicians' services will be reviewed by the Senate Committee on Finance's Subcommittee on Health at a November 18 hearing, Chairman Bob Packwood (R-Oregon) announced today.

The Subcommittee hearing is scheduled to begin at 9:15 a.m., Monday, November 18, 1985, in Room SD-215 of the Dirksen Senate Office Building.

Senator Packwood said Senator Dave Durenberger (R-Minnesota), Chairman of the Subcommittee on Health, would preside at the hearing.

Senator Packwood explained the hearing has been called to examine the efforts under way by the Department of Health and Human Services (HHS) and others which assess the current payment mechanism and develop reform options.

Washington, D.C. 20540

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PHYSICIAN REIMBURSEMENT UNDER MEDICARE

Background Paper

Prepared for the Use of the Members of
The Committee on Finance

Jennifer O'Sullivan
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Specialists in Social Legislation
Education and Public Welfare Division
December 3, 1985

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PHYSICIAN REIMBURSEMENT UNDER MEDICARE

I. OVERVIEW

Medicare's expenditures for physicians' services increased at an average annual rate of 20.6 percent over the 1979-1983 period. As an interim measure to control these escalating costs, Congress approved in 1984, a 15-month freeze on physicians' fees under the program. The freeze period was slated to end September 30, 1985. P.L. 99-107 and P.L. 99-155 extended the freeze period through December 14, 1985. On November 14, 1985 the Senate amended and passed H.R. 3128, making it the Consolidated Omnibus Budget Reconciliation Act of 1985. This measure extends the freeze until September 30, 1986 for "nonparticipating" physicians and lifts the freeze for "participating" physicians. The freeze provisions are viewed, however, as a temporary means of stemming increases in program expenditures for physicians' services.

Medicare pays for physicians' services on the basis of Medicare-determined "reasonable charges." The reasonable charge is the lowest of:

(1) the physician's actual charge for the service;

(2) the physician's customary charge for the service; or

(3) the prevailing level of charges made for the service by all physicians in the same geographic area.

Prior to the freeze, customary and prevailing charge screens generally were updated annually, with increases in prevailing charges limited by an economic index that reflects general inflation and changes in physicians' office practice costs.

Medicare payments are made directly either to the doctor or the patient depending on whether the physician has accepted assignment for the claim. In the case of assigned claims, the beneficiary transfers his payment rights under Medicare to the physician. In return, the physician agrees to accept Medicare's reasonable charge as payment in full (except for applicable cost-sharing). If the physician does not accept assignment, Medicare payments are made to the beneficiary who, in turn, pays the physician. Beneficiaries are liable for required deductible and coinsurance amounts and, in the case of non-assigned claims, for any difference between Medicare's reasonable charge and the physician's actual charge.

The Deficit Reduction Act of 1984 (DEFRA) froze Medicare recognized customary and prevailing charges for all physicians' services provided during the 15-month period beginning July 1, 1984 at the levels in effect on June 30, 1984. However, subsequent legislation extended the freeze period through December 14, 1985.

DEFRA also established the participating physician and supplier program. Participating physicians or suppliers agree to accept assignment for all services provided to all Medicare patients during a 12-month period. The first such period began October 1, 1984. The primary incentive for physicians to participate is the ability to raise actual charges during the freeze period so that such increases may be reflected in the calculation of customary charges in subsequent years. Nonparticipating physicians cannot raise their actual charges during the freeze period above the levels they charged during April-June 1984.

The Medicare fee-for-service payment system has undergone relatively few changes since the program's inception. It has been criticized by some because it allegedly permits distortions in payments and fails to provide adequate

protection for the elderly against rising physicians' fees. These concerns are reflected in:

(1) imbalances in payments for individual services, and

(2) in the unit of payment.

With respect to payment imbalances, Medicare frequently recognizes a higher fee when the same service is performed by a specialist rather than by a general practitioner or when provided in a hospital rather than in an office setting. There is also a wide variation in recognized fees between various geographic regions. Further, physicians generally are paid substantially less for their primary care skills than for their technical skills. Finally, new procedures generally are priced at a high level and charges generally are not lowered over time even though increased experience and higher volume actually have reduced both the costs and time involved.

Use of the individual service as the payment unit also has been the subject of criticism. While some surgeons are essentially paid a single comprehensive fee for an inpatient case, including both pre- and post-operative care, the majority of all physicians' payments are made for each unit of service. It has been argued that this reimbursement system encourages physicians to provide additional services (such as laboratory tests), order additional consultations, or perform additional surgeries. While these actions may not be outside the broad range of accepted medical practice, other less costly alternative treatment patterns may be equally, or in some cases more, appropriate. Another frequently cited problem with the current unit of payment is the phenomenon known as "unbundling," i.e., billing separately for services that preveiously had been consolidated into a larger service category and therefore payment unit; the total amount paid for such multiple individual services may exceed the amount which would have been paid if they had been grouped under a single category, i.e., "bundled."

It also has been suggested that existing coding policies are somewhat inflationary. Procedure codes for some high volume procedures such as office visits are not precisely defined; it may thus be possible to describe the same service by more than one code, giving the physician the option of selecting the code with a higher allowable charge (so-called code-creep).

Physicians' decisions about pricing and billing have a direct economic impact on beneficiaries both in terms of the required 20 percent cost-sharing amounts and the amounts in excess of approved charges on unassigned claims.

For several years, both the Congress and the Administration have been exploring alternative approaches to containing escalating expenditures for physicians' services. Three long-term reform options which have been suggested are:

(1) fee schedules based on a relative value scale (RVS);

(2) predetermined comprehensive payments for physicians' services provided to hospital patients based on the patient's diagnosis (so-called physician DRGs); and

(3) capitation.

The first option for revising Medicare's reimbursement system would be to establish a uniform national fee schedule for all physicians' services. Fee schedules are set payment amounts for each service. The most frequently suggested method for establishing a fee schedule would be to utilize an RVS which weights each service in relation to other services. The RVS is then translated into a fee schedule (dollar amount) by use of a predetermined conversion factor or multiplier. The use of a national fee schedule has the following advantages:

(1) Wide payment fluctuations among physicians in payments for similar services would be removed, though certain area-wide adjustments for cost-of-living differentials might be permitted;

(2) Medicare payments to physicians would be known in advance; and

(3) Medicare would exercise control over the amount the program would pay for individual services.

The primary disadvantage of this approach is that it would not provide control over total expenditures since it retains the individual service as the payment unit. Thus, this approach could have less impact than other reform options such as capitation unless controls on intensity and volume were also incorporated in the new system.

The second reform option which has been suggested is the use of predetermined comprehensive payments for physicians' services provided to hospital inpatients based on the patient's diagnosis. The "Social Security Amendments of 1983" (P.L. 98-21) established a prospective payment system (PPS) for inpatient hospital services based on diagnosis-related groups (DRGs). P.L. 98-21 also required the Department to study the advisability and feasibility of extending this approach to physicians' services. The report, due July 1, 1985, has not been transmitted to the Congress. It was expected that a physician DRG payment system for inpatient services would involve the establishment of a predetermined rate for each of the 468 DRGs used under the PPS system. However, there is some concern that the existing DRG classification system, which was designed to reflect hospital costs, may not adequately reflect differences in physician input costs. Another issue in designing a physician DRG payment system is determining to whom the payment should actually be made; payments could be made to the admitting physician, medical staff of the hospital or the hospital itself. One consideration in making this choice is the degree of financial risk that may be imposed on the various parties involved. This risk reflects the proportion of sicker patients treated and how widely the risk is spread.

A physician DRG payment system would give physicians (or physician groups) the incentive to practice more efficiently since they would be at risk for any costs in excess of the package price. This payment approach would directly address the problem of unbundling for services provided in the inpatient setting.

It would also address the divergence of economic incentives that currently exist between hospitals and physicians. However, the concern has been expressed that if hospital and physician incentives are too closely aligned, the quality of patient care may be affected adversely.

While a physician DRG payment approach would limit expenditures for individual admissions, it might not control overall expenditures. For example, physicians could change their practice patterns such that:

(1) certain complex cases would be managed in two or more admissions instead of one; and

(2) some services related to the inpatient stay could be performed in outpatient settings either before or after the hospital stay and be billed for separately.

A third reform option is capitation. Under this type of system, Medicare would pay entities, such as health maintenance organizations or private insurers, a predetermined per person monthly fee or capitation payment. In return, the entities would be responsible for financing a specified set of benefits, including physicians' services. One advantage of this approach is that the organization would have a financial incentive to control costs. However, if the capitation payment is too low, the approach could lead to underutilization and a decline in the quality of care. Medicare currently pays risk-contracting health maintenance organizations and competitive medical plans on a capitated basis for benefits provided to a small proportion of the Medicare population who have voluntarily enrolled in these plans. It has been suggested that capitation payments could also be made to insurers who would provide benefits to all beneficiaries in a geographic region. However, there is little experience with this approach. A major issue in the design of a capitation system is how to determine the appropriate level of the capitation payments.

Regardless of the reform option chosen, physician assignment/participation issues would need to be examined. One approach would retain current policy.

Another would require physicians to accept Medicare's payment rate as the full payment (plus the required coinsurance).

In connection with its continuing interest in physician reimbursement issues, the Congress required the Department to prepare two reports for submission in July 1985. The first report, noted above, concerns the possible application of a DRG type payment system to physician services provided in the inpatient hospital setting. The second is to examine the impact of the freeze on the volume and mix of services provided. The Congress also required the Office of Technology Assessment (OTA) to prepare a report on physician payments to be submitted by December 31, 1985.

II. CURRENT PROGRAM

A. Medicare Coverage of Physicians' Services

Total Medicare outlays were $62.7 billion in FY84; of this amount, $42.3 billion were Part A outlays and $20.4 billion were Part B outlays. Of Part B outlays, 73 percent represented payments for physicians' services ($14.9 billion). Physicians' services covered by Medicare include those provided by doctors of medicine and osteopathy, whether furnished in an office, home, hospital or other institution. Also included under certain limited conditions are services of: dentists (when performing certain surgeries or treating oral infections), podiatrists (for certain non-routine foot care), optometrists (for services to patients who lack the natural lens of the eye), and chiropractors (for treatment involving manual manipulation of the spine, under specified conditions). Medicare payments accounted for 18 percent of the income of all physicians in 1982.

The Part B program generally pays 80 percent of the "reasonable charge" for covered services after the beneficiary has met the Part B annual deductible amount of $75. The beneficiary is liable for the 20 percent coinsurance charges, plus, in certain cases, physicians' charges in excess of the Medicare-determined "reasonable charge."

Five specialties accounted for over half of Medicare physician spending in 1983. These were:

(1) internal medicine (20 percent of the total);
(2) ophthalmology (10 percent);
(3) general surgery (9 percent);
(4) radiology (8 percent); and
(5) general practice (6 percent).

Medical care (primarily physicians' visits) accounted for 37 percent of Medicare spending for physicians' services while surgery accounted for 34 percent in 1983. (The remaining 29 percent includes diagnostic laboratory and x-ray services, anesthesia services, and consultations). Sixty-two percent of spending is for services delivered in hospital inpatient settings while 29 percent is for services rendered in physicians' offices. (The remaining 9 percent includes services rendered in hospital outpatient departments and skilled nursing facilities).

For the aged, Medicare spending accounted for an estimated 57.8 percent of the per capita expenditures for physicians' services in 1984 ($502 out of total $868). Out-of-pocket spending by the aged accounted for $227 (26.1 percent); private insurance spending represented $117 (or 13.5 percent) and other government spending $22 (2.5 percent).

Medicare is administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (DHHS). The day-to-day functions of reviewing Part B claims and paying benefits are performed by entities known as "carriers." These are generally Blue Shield plans or commercial insurance companies.

B. "Reasonable Charges"

Medicare pays for physicians' services on the basis of "reasonable charges," sometimes referred to as "approved charges." A reasonable charge for a service (in the absence of unusual circumstances) cannot exceed:

-- the actual charge for the service;

-- the physician's customary charge for the service; and

-- the "prevailing charge" billed for similar services in the locality (set at a level no higher than is necessary to cover the 75th percentile of customary charges).

Carriers delineate localities for purposes of determining prevailing charges on the basis of their knowledge of local conditions. Localities are usually political or economic subdivisions of a State. There are 225 localities nationwide.

Prior to 1984, customary and prevailing charge screens (i.e., benchmark limits against which actual charges are compared) were updated every July 1. Since 1975, the annual update in the prevailing charge screens has been subject to a limitation. This limitation (expressed as a maximum allowable percentage increase) is tied to an economic index known as the Medicare Economic Index (MEI) that reflects changes in operating expenses of physicians and in earnings' levels.

Because DEFRA froze physicians' fees through September 30, 1985, the annual increases in the customary and prevailing charge screens slated for July 1, 1984, did not occur. Subsequent updates were slated to occur October 1 of future years beginning in 1985. However, recent legislation postponed until December 14, 1985 the update otherwise slated to occur on October 1, 1985.

C. Assignment and Participation

Medicare payments are made directly either to the doctor or to the patient depending upon whether or not the physician has accepted assignment for the claim. In the case of assigned claims, the beneficiary transfers his right to the Medicare payment to the physician. In return, the physician agrees to accept Medicare's reasonable charge determination as payment in full for covered services. The physician bills the program directly and is paid an amount equal to 80 percent of Medicare's reasonable or approved charge (less any deductible, where applicable). The patient is liable for the 20 percent coinsurance. The physician may not charge the beneficiary (nor can he collect from another party

such as a private insurer) more than the applicable deductible and coinsurance amounts. When a physician accepts assignment, the beneficiary is therefore protected against having to pay any difference between Medicare's reasonable charge and the physician's actual charge.

In the case of non-assigned claims, payment is made by Medicare directly to the beneficiary on the basis of an itemized bill paid or unpaid. The beneficiary is responsible for paying the physician's bill. In addition to the deductible and coinsurance amounts, the beneficiary is liable for any difference between the physician's actual charge and Medicare's reasonable charge.

A physician (except a "participating physician") may accept or refuse requests for assignment on a bill-by-bill basis, from different patients at different times, or from the same patient at different times. However, he is precluded from "fragmenting" bills for the purpose of circumventing reasonable charge limitations. He must either accept assignment or bill the patient for all of the services performed on a single occasion. Additionally, when a physician treats a patient who is also eligible for Medicaid, the physician essentially is required to accept assignment. Total reimbursement for services provided to these dual eligibles is equivalent to the Medicare-determined reasonable charge with Medicaid picking up the required deductible and coinsurance amounts.

The law specifies that a physician who knowingly, willfully, and repeatedly violates his assignment agreement is guilty of a misdemeanor. The penalty for conviction is a maximum $2,000 fine, up to 6 months' imprisonment, or both.

In calendar year 1983, approximately 56 percent of claims were paid on an assignment basis. In 1984, the figure rose to 59 percent. By May 1985, the the figure was 69 percent. This recent increase primarily was attributable to two factors -- the beginning of the participating physicians program on

October 1, 1984, and the requirement that, effective July 1, 1984, claims for independent laboratory services be assigned.

DEFRA established the concept of a "participating physician." A participating physician is one who voluntarily enters into an agreement with the Secretary to accept assignment for all services provided to all Medicare patients for a future 12-month period. The first such period began Oct. 1, 1984; the second period began on October 1, 1985. The law requires physicians to sign up prior to October 1 for the following 12-month period. After this date, only new physicians in an area or newly licensed physicians may enter into a participation agreement until the beginning of the next designated time period.

Participating-physicians are subject to the freeze which has been extended through December 14, 1985. They are, however, permitted to increase their billed charges during the freeze period as an incentive to encourage participation. While increases in billed charges will not raise Medicare payments during the freeze period, these charges will be reflected in the calculation of future customary charge screen updates. The law includes additional incentives for physicians to agree to become participating physicians. These include the publication of directories identifying participating physicians and the maintenance by carriers of toll-free telephone lines to provide beneficiaries with names of participating physicians.

Non-particpating physicians (i.e., those who have not signed a voluntary participation agreement) can continue to accept assignment on a case-by-case basis. They cannot, however, increase their billed charges during the freeze period over the amounts charged for the same services during the April 1 - June 30, 1984 base period. For example, if during that period a physician charged $22 for a service and Medicare's reasonable charge was $20, he could bill the beneficiary the 20 percent coinsurance ($4) plus (if he did not accept

assignment on this claim) the $2 in excess of the reasonable charge. During the freeze period, the nonparticipating physician's fee is frozen at $22 -- he can not raise his charges to beneficiaries in an attempt to circumvent the freeze.

The law requires the Secretary to monitor charges of nonparticipating physicians to determine whether or not there is compliance with the fee freeze. The monitoring is to compare actual charges of individual physicians with their corresponding charges during the base period (Apr. 1, 1984, through June 30, 1984). Nonparticipating physicians who do not comply with the freeze could be subject to civil monetary penalties or assessments, exclusion for up to 5 years from the Medicare program, or both.

HCFA reported that in FY85, 29.8 percent of physicians were "participating;" 34.0 percent of limited license practitioners (i.e., chiropractors, dentists, podiatrists) were "participating;" and 23.8 percent of Medicare suppliers were "participating."

D. Consolidated Omnibus Budget Reconciliation Act of 1985 (H.R. 3128)

On November 14, 1985 the Senate amended and passed H.R. 3128, making it the Consolidated Omnibus Budget Reconciliation Act of 1985. The Senate amendment includes a provision which would extend the current freeze on customary and prevailing charges through September 30, 1986 for physicians who are nonparticipating physicians during FY86. Prevailing charges for services furnished after the freeze would not include an allowance for the lack of an increase during the freeze. The Senate amendment would also extend the freeze on actual charges on nonparticipating physicians. This freeze is tied to the April-June 1984 levels. A physician who converts from a participating physician in FY85 to a nonparticipating physician in FY86 would have his actual charges made during the 12-month period beginning April 1, 1984 reflected in the calculation

of customary charges for FY86; further, this physician would not be allowed to increase actual charges in FY86 above the level in effect for the 3-month period beginning April 1, 1984. The monitoring of nonparticipating physicians' actual charges would continue through FY86.

The Senate amendment would provide that any physician who signs a participation agreement for FY86 would receive an increase in Medicare payments in that year. Both participating and nonparticipating physicians would receive an increase in Medicare payments beginning in FY87. However, there would be a permanent 1-year lag in prevailing charge levels applicable for nonparticipating physicians versus participating physicians. The Senate amendment would require publication of directories (rather than a single directory, as is currently required) identifying participating physicians. In addition, the Explanation of Medicare Benefits (EOMB) notices sent to beneficiaries would be required, for nonassigned claims, to include a reminder of the participating physician and supplier program.

The Senate amendment would also specify that the penalties for noncompliance with the fee freeze provisions would not be applicable in those instances where no payment is requested or billed for under Part B.

III. CURRENT SYSTEM PROBLEMS

Part B is currently financed through enrollee premiums (approximately 25 percent of Part B expenditures) and Federal general revenues. The rapid cost increases and the resulting impact on the Federal budget are causing increasing concern. Since approximately three-quarters of Part B outlays are for physicians' services, the primary focus has been on ways to curb these expenditures. Initially, consideration was given to refining the existing reimbursement system. However, more recently attention has turned to consideration of alternative payment methodologies.

A. Prices for Individual Services

As noted, Medicare pays for individual services on the basis of "reasonable" charges. Reasonable charges cannot exceed the physician's customary charge or the prevailing charge for the service in the locality. The prevailing charge was originally set at the level necessary to fully cover at least the 75th percentile of customary charges. However, annual increases in recognized prevailing charge levels are subject to the economic index limitation (which is expressed as an allowable percentage increase). Physicians' fees generally have increased at a faster rate than the economic index. Between 1973 and 1984, the economic index increased by 106 percent while physician fees for services to all patients, as measured by the physicians' services component of the Consumer Price Index (CPI), increased 157 percent. Thus, each year an increasing percentage of physicians' customary charges are likely to exceed the index-adjusted

prevailing charge limit. In these cases, the limit determines the approved payment amount. Estimates vary on the percentage of claims which are subject to the economic index-adjusted prevailing charge screen; it is generally believed that at least one-half of charges are subject to this limit.

The index-adjusted prevailing charge screens are serving as de facto fee schedules in many localities. Fee schedules are set payment amounts for each service. (For example, if the fee schedule amount is $20 for an initial brief office visit, this is the amount paid for the visit regardless of the physician's charge.)

These de facto fee schedules, which vary considerably throughout the country, reflect and lock into place historical imbalances in charging patterns. Many feel that these imbalances have encouraged physicians to locate in high-income areas, to choose specialty over primary care practice, to treat patients in hospitals rather than outpatient settings and to perform surgical rather than medical procedures. Some of the major problems which have been cited follow:

1. General Practitioner/Specialist Differential. Considerable variation exists in Medicare-determined reasonable charges for services performed by physicians in general practice versus reasonable charges for similar services performed by specialists. For example, the prevailing charge for a routine follow-up office visit may be $25 for a general practitioner and $30 for a specialist. In the 1984 fee screen year (i.e., July 1, 1983, through June 30, 1984), Medicare carriers recognized specialty reimbursement differentials in all areas of the country except for Florida, the area of Kansas served by Blue Shield of Kansas, North Dakota, South Dakota and the area of New York served by Blue Shield of Western New York.

The specialist/generalist differential recognized by Medicare and many private insurers was originally intended to reflect the fact that specialists

often charge more because they provide a different type or higher quality of service. It has also been argued that specialists deserve higher fees in order to compensate them for the additional years of training they must receive in order to become a "board-certified" specialist. However, it has been noted that not all doctors paid as specialists under Medicare are board-certified.

While some believe that specialists may deserve higher fees when practicing within their specialty, many specialists also provide a significant amount of primary care. The fee differentials mean that Medicare is paying significantly more for what many feel are comparable services. For example, in fee screen year 1984, the mean prevailing charge for specialists was 16 percent higher than that for generalists for a "brief follow-up hosptial visit" and 24 percent higher for a "brief follow-up office visit."

Neither Medicare nor the medical community generally have established a single uniform definition for the term specialist. A report by the General Accounting Office (GAO/HRD-84-94, Sept. 27, 1984) reviewed how carriers establish prevailing rate structures and identified several problems areas. It stated that HCFA had given little guidance to the carriers in determining whether specialty differentials in fees were warranted for particular procedures, and that in turn, the carriers had conducted little or no analyses of this issue. The report cited wide differences in the way carriers recognize physician specialties in establishing prevailing charges. Some carriers did not recognize any specialties and had only one prevailing charge for a particular procedure. Others developed prevailing charges for each specialty individually. Others combined numerous specialties into several prevailing charge groups. The report noted that the use of more than one prevailing charge could lead to significant variations among physician specialties. For example, the prevailing charge for a "consultation requiring a comprehensive history" in an urban area

of Massachusetts ranged from $40.00 for a general practitioner to $89.50 for a cardiologist or pulmonary disease specialist.

The GAO report also examined the practice of "self-designation" -- i.e., a physician classifying himself as specialist without being board-certified (i.e., certified by the specialty organization as having met certain training and competency requirements). In a review of three carriers, it was noted that approximately one-half of the physicians who self-designated a specialty were not board-certified in that specialty and about one-fourth of the physicians who designated themselves as subspecialists in internal medicine were not even board-certified in internal medicine.

2. Geographic Variations. Significant variations in Medicare-determined reasonable charges exist by geographic area. Differences occur between urban and rural areas, among the States and between various regions. For example, an analysis of fee screen year 1984 data showed that for a brief follow-up hospital visit (one of the most frequently billed services) the prevailing charge ranged from $8.30 in one locality in Wisconsin to $50 in New York City, a difference of 500 percent. In part, these geographic variations in fees reflect differences in the cost of doing business, such as differences in the cost of office space, salaries of support personnel, and malpractice insurance. Also, since physicians generally can not charge Medicare patients more than they charge their private pay patients for the same service, these differences in charges reflect variations in private sector charges. However, some have expressed concern that the magnitude of these variations encourages physicians to locate in high-fee areas, such as large cities, while reducing the availability of medical care in low-fee areas, such as rural communities.

3. Failure of Prices to Fall as Practice Patterns Change. Physicians' charges for new procedures generally are set at a high level reflecting the

fact that new procedures initially may require special skills and a substantial amount of a physician's time. However, the charge accepted for a new procedure becomes the base for future increases. Physicians generally do not lower their charges even though increased experience, higher volume, and technological changes have actually lowered the costs and time required to provide the service. An example frequently cited of a failure of charging patterns to reflect changes in practice patterns is that of coronary artery bypass surgery which is now a frequently performed procedure (50,000 under Medicare in 1982) but one whose charges have remained relatively high.

Some analysts have suggested that it might be appropriate to lower or modify the calculation of the reasonable charges for certain procedures. However, limited data exists on which procedures should be targeted and what charge levels would be appropriate.

4. Variations by Place of Performance. Physicians' services provided in an inpatient hospital setting are generally associated with higher reimbursement levels. For example, in fee screen year 1984, the mean prevailing charge for a "brief follow-up visit performed by a general practitioner was 21 percent higher in a hospital than in an office. For the same service performed by a specialist, the mean prevailing charge was 12 percent higher in a hospital than in an office. While hospitalized patients may require more intensive care, the physician does not bear the associated office costs such as overhead. Similarly, the cost to a physician of providing a service in a hospital outpatient department is lower than the cost of providing the identical service in his private office. The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) authorized the Secretary to limit the reasonable charge for services furnished in a hospital outpatient department to a percentage of the prevailing charge

for similar services furnished in an office. The implementing regulations set the limit at 60 percent.

5. Medical/Surgical ("Cognitive/Procedural") Differentials. Hospital-based procedures, particularly surgical procedures and those requiring expensive fixed equipment (such as certain diagnostic tests) generally are priced higher than office-based services. This raises the concern that the existing payment mechanism may encourage the performance of services, particularly surgical procedures, which not only command high physicians' charges but also consume large amounts of support and technical resources. A parallel concern is that the system may discourage physicians from spending time with patients to counsel or examine them. Thus, rather than spending the time needed to determine the minimum set of diagnotic tests that are medically necessary, the physician has a financial incentive to order additional tests. There are also some patients with problems that could be treated either medically (such as with drugs or other therapies) or surgically. While it is arguable that for some cases a medical approach is less risky and should be preferred, the current payment system encourages a surgical approach to treatment. The resulting payment imbalances are sometimes referred to as the "cognitive/procedural differential."

A few attempts have been made to determine the relative value of surgical procedures and medical office visits on the basis of resource costs as opposed to charges. A study by William Hsaio and William Stason 1/ focused on the professional time expended and the complexity of the service. After standardizing for complexity between selected procedures, the study showed that physicians

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1/ Hsiao, William C. and Stason, William B. Toward Developing a Relative Value Scale for Medical and Surgical Services. In Health Care Financing Review, v. 1, n. 2. Fall 1979, p. 23-38.

were paid as much as 4-5 times more per hour for hospital-based surgery than for office visits.

B. Unit of Payment

Another concern about current Medicare reimbursement methodology is the use of an individual service as the payment unit. For example, physicians can bill separately for an initial office visit, a follow-up office visit and for each individual lab test or x-ray procedure performed. While some surgeons are essentially paid a single comprehensive fee for an inpatient case including both pre- and post-operative care, the majority of all physician payments are made for each unit of service.

It has been argued that the reimbursement system encourages physicians to provide additional services (such as laboratory tests), order additional consultations, or perform additional surgeries. While these actions may not be outside the broad range of accepted medical practice, other less costly alternative treatment patterns may be equally, or in some cases, more appropriate. These treatment decisions also have an impact on total health expenditures. It is estimated that physicians' decisions directly influence 70 percent of all health spending.

Another frequently cited problem with the current unit of payment is the phenomenon known as "unbundling," i.e., billing separately for services that could be consolidated into a larger unit of service and therefore payment. For example, instead of charging a single comprehensive fee for a surgical case, a physician could submit separate charges for the surgery and for each of the pre- and post-operative office and hospital visits. It has been argued that the total amount the program pays for such multiple individual services frequently exceeds the amount which would have been paid if they had been grouped under

an individual service category, i.e., "bundled." Unbundling is frequently cited as a significant contributor to increases in expenditures for physicians' services.

It also has been suggested that existing coding policies may be inflationary. Procedure codes for some high volume services such as office visits are not defined precisely. It therefore may be possible to describe the same service by a code with a higher allowable charge, for example a "brief visit" might become an "intermediate visit." This phenomenon has been labeled "code creep." There is also some question whether the increased number of individual procedure codes (rising from 2,000-2,500 in 1966 to over 6,000 today) may facilitate code creep.

The impact of these factors on Medicare expenditures is reflected in historical data on the components of increases in recognized charges per enrollee for physicians' services. The 1985 Annual Report of the Board of Trustees of the Supplementary Medical Insurance Trust Fund disaggregates increases in expenditures per enrollee for physician services into two components: price increases per unit of service and "net residual factors." The latter component includes increases in expenditures due to additional physician services per enrollee, greater use of specialists, use of more expensive techniques and technology, and other factors. For the year ending June 30, 1983, over half of the total percentage increase in physician expenditures per enrollee was due to the "net residual factors (10.8 percent out of a total of 20.6 percent). For the following year, the residual factors were expected to account for about a third of the total increase per enrollee (3.2 percent out of a total 10.4 percent). Projections for subsequent years show a decline in the rates. During FY85 (while the freeze was in effect) the overall projected rate of increase was 5.5 percent with net residual factors accounting for 3.2 percent.

Volume increases, unbundling, code creep and more extensive use of expensive services are thus important factors determining the level of overall expenditures for physicians' services. Several studies have shown that when limits are placed on allowable fees, increases in these residual factors may result. Experience during the Economic Stabilization Program (ESP) during the early 1970s is frequently cited as an illustration of this phenomenon. Analysis by the Urban Institute of the impact of the ESP in California showed that physicians countered attempts to control prices by increasing the volume of services provided and changing to a more complex service mix. In fact, gross Medicare incomes of these physicians actually increased more during the 2 years of price controls than in the year after the controls were lifted.

C. Patient Liability

Physicians' decisions about pricing and billing have a direct economic impact on patients. All Medicare patients are liable for the 20% coinsurance charges, though Medicaid or privately purchased "Medi-Gap" insurance may pay for some of these costs. In addition, when the physician does not accept assignment, beneficiaries are liable for amounts in excess of Medicare's approved or reasonable charge, an amount frequently not covered by "Medi-Gap" insurance policies.

The difference between the physician's billed charge and Medicare's reasonable charge is referred to as the "reasonable charge reduction." Reasonable charge reductions were made on 83.1 percent of unassigned claims in FY84. The amount of the reduction was 23.6 percent of billed charges or $29.69 per approved claim. Beneficiaries thus faced an effective coinsurance of 43.6 percent on unassigned claims. Aggregate reasonable charge reductions on unassigned claims in FY84 were $2.7 billion. Beneficiaries were liable for these reduction

amounts. Comparable reasonable charge reductions were recorded for assigned claims though the beneficiaries were not liable for the reduction amounts.

The impact of reasonable charge reductions on unassigned claims is spread unevenly across the population. Nationwide, 59 percent of claims were paid on an assigned basis in 1984. The AMA Center for Health Policy Research 2/ reported that for physicians who treated some Medicare patients in 1984, 83.9 percent accepted assignment for at least some patients, an increase over the 75.6 percent recorded in 1982. In 1984, 32.1 percent of physicians always accepted assignment, and 16.1 percent never accepted assignment. The average percentage of patients assigned was 51.3 percent. Physician assignment behavior varied by region with the percentage of physicians that accepted assignment for one or more Medicare patients ranging from 78.2 percent in the North Central Region to 89.0 percent in the Northeast. Similarly, variations were recorded by specialty with the percentage accepting assignment for one or more patients ranging from 79.5 percent for general and family practitioners to 91 percent for internists.

Until recently, all physicians have been able to accept or refuse assignment on a claim-by-claim basis. However, under the provisions of the Deficit Reduction Act of 1984, physicians may become "participating physicians." Participating physicians agree to accept assignment on all claims for the forthcoming year. Nonparticipating physicians can continue to accept or refuse assignments on a case-by-case basis. As of this time, data is not available on how the implementation of the participating physician provision has affected beneficiary out-of-pocket payments. Individual beneficiary payments may go up,

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2/ Medicare Assignment: Recent Trends and Participation Rates, Socioeconomic Monitoring System Report. American Medical Association, v. 4, n. 1, February 1985.

down or remain constant depending on whether the physician does or does not become a participating physician, and in the case of a nonparticipating physician, whether there is a change in the percentage of cases paid on an assigned basis.

IV. REFORM OPTIONS

For several years, the Congress and the Administration have been exploring alternative approaches to contain escalating expenditures for physicians' services under Medicare. Both have been wary of proposals to freeze customary and prevailing charges primarily because of the concern that more physicians would refuse assignment, thereby passing along to the beneficiary the cost increases not reflected in the program's approved charges.

DEFRA included a 15-month freeze on physicians' fees and established the concept of "participating" physicians. The law attempted to protect beneficiaries from increased liability in connection with non-assigned claims by prohibiting nonparticipating physicians from raising their billed charges during the freeze period. The Consolidated Omnibus Budget Reconciliation Act of 1985 (H.R. 3128), as passed by the Senate, extends the freeze for non-participating physicians through FY86. However, the freeze provisions have been viewed as an interim approach until more permanent changes could be incorporated into the system.

Serious consideration of major reform options has been hampered by the following factors:

(1) major gaps in the data on what the program is currently paying for;

(2) physician opposition to a major alteration in the current fee-for-service/voluntary assignment system; and

(3) uncertainty concerning the actual impact of major reforms on both the program and beneficiaries.

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However, in addition to rising fiscal concerns, changes in the health services marketplace as a whole and the Medicare program itself have generated increasing interest in reform options. The health services marketplace is increasingly subject to competitive pressures. This is reflected in increasing competition among physicians for patients in response to the developing oversupply of physicians (which is estimated by the Graduate Medical Education National Advisory Committee at 63,000 in 1990); the increasing emphasis given by employers to obtaining lower cost insurance protection; the growth in the number of health maintenance organizations (HMOs); and the rapid rise of preferred provider organization (PPO) arrangements under which services are provided to subscribers at discounted prices.

At the same time that these changes are occurring in the health services marketplace, Medicare is implementing a major new prospective payment system (PPS) for hospitals which is replacing the earlier "reasonable cost" reimbursement system. The PPS system has altered the economic incentives for hospitals by encouraging them to keep patients hospitalized for as short a period as is medically necessary and to perform as few tests and procedures as are needed while the patient is hospitalized. The economic incentives for hospitals under PPS are thus significantly different from those for physicians who are providing and ordering services in the inpatient setting.

These changes have served to focus attention on ways of changing the existing economic incentives for physicians by changing the method of payment. Studies of a number of options and related issues are currently being conducted by HCFA, the Office of Technology Assessment, and other public and private entities.

The major alternatives which are being examined are:

(1) fee schedules (based on a relative value scale);
(2) physician DRGs; or
(3) capitation.

Reforms to the existing reimbursement system could be limited to services provided in an inpatient hospital setting (approximately 62 percent of physicians' expenditures) or could be applied to all physicians' services. Payment reforms either might be taken apart from or in concert with reforms in the current assignment system. Finally, reforms could be included as part of more extensive reforms in the Medicare program as a whole.

A. Fee Schedules

Fee schedules are set payment amounts for each service. For example, if the fee schedule amount is $20 for an initial office visit, this is the approved payment amount regardless of the physician's charge. As noted earlier, Medicare's limit on year-to-year increases in prevailing charges (i.e., the economic index limit) has led, in effect, to the use of de facto fee schedules in some localities. These de facto fee schedules are more often reflective of historical charging patterns rather that actual input costs.

One option for revising Medicare's reimbursement system would be to replace the current de facto fee schedules based on local charging patterns with a uniform national fee schedule. This would have the advantage of removing the wide payment fluctuations for similar services though certain area-wide adjustments for cost-of-living differentials might be permitted. Physicians would know in advance what Medicare's payment would be. This approach would not provide control over total expenditures since it retains the individual service as the payment unit.

Several methods have been suggested for developing a uniform fee schedule. The schedule could be based on a relative value scale, existing charging patterns, or negotiation with representatives of the physician community. These methods are not mutually exclusive. Elements of all three

frequently are incorporated in discussions of a fee schedule based on a relative value scale (RVS).

An RVS is a method of valuing individual services in relationship to each other. An RVS is a table of weights that defines the relative values of services. Each service is assigned a weight. For example, an initial office visit could be assigned a weight of 2.5 and other services assigned higher or lower weights to indicate their "value" relative to an initial office visit. An RVS is not a fee schedule. It is translated into a fee schedule by use of a "conversion factor" or multiplier. For example, if the multiplier were $6, a service with a relative value of 2.5 would be priced at $15.00. There are a number of factors that might be considered in determining the appropriate level of the RVS multiplier. Since the multiplier determines how much will be paid, it could be used to control or limit aggregate expenditures for physician services.

RVSs are frequently discussed in terms of a weighting system that would reflect the physician's time, skill, and overhead costs required to provide each service. The goal would be to establish RVSs that yield fee schedules which eliminate or reduce the existing payment imbalances.

To date, RVSs have generally been developed on the basis of historical charging patterns. The best known RVS was developed by the California Medical Association (CMA). The California RVS (CRVS) was established in 1956 and subsequently revised several times. The most recent editions were based on charge data derived from claims files of third party payers in the State. No attempts were made to adjust the charge data to reflect alternative measures of relative "value," such as physician time or resource consumption. Several other professional societies also developed RVSs though many of these were based on the California model.

The use and development of RVSs was generally halted by the antitrust action of the Federal Trade Commission (FTC) in 1979. The FTC issued a consent notice which required the CMA to cease publishing, promulgating, or participating in the use of RVSs; further, previously issued schedules had to be withdrawn. In early 1985, the FTC issued an advisory letter to the American Society of Internal Medicine expressing the concern that RVSs developed by medical societies could be viewed as price fixing schemes.

There are several studies underway which attempt to determine the relative values of physician services. Hsaio and Stason 3/ have developed a method for creating an RVS based on physician time, complexity of service and similar factors. Egdahl and Manuel 4/ have used a "consensus panel" (i.e., expert group decision making) approach to utilize expert opinions to measure the relative complexity and severity of common surgical procedures. The Institute of Medicine is planning a 2-year study which would develop a set of principles for valuing physicians' services and then apply them to establish relative values for selected services.

A number of segments of organized medicine including the American Medical Association (AMA) and the American Society of Internal Medicine (ASIM) have expressed strong interest in developing or assisting in the development of an RVS.

A study by the Urban Institute 5/ attempted to explore various means of constructing RVSs. The study concluded that available information on such factors as time per procedure, complexity, severity, and resource costs is

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3/ Hsiao and Stason, op. cit.

4/ Egdahl, Richard H. and Manuel, Barry. A Consesus Approach to Determine the Relative Complexity-Severity of Frequently Performed Surgical Services. Surgery, Gynecology and Obstetrics, May 1985, v. 160, p. 403-406.

5/ Urban Institute. Final Report on Alternative Methods of Developing a Relative Value Scale of Physicians' Services, October 1984.

insufficient to allow timely development of a reliable cost-based RVS. The authors concluded that an initial RVS based on charge data was the preferable alternative. The report suggested that a "consensus development" process such as the method utilized by Egdahl and Manuel could serve a useful role in the review, evaluation, and adjustment of an RVS based on charges. Using this approach, an "expert panel" would modify the charge-based index values which appeared out of line based on subjective valuations of other factors such as production costs or complexity. The final report recommended the following three-step process:

(1) development of a relative "cost" scale based on modifications of a relative charge scale;

(2) conversion of the relative cost scale into a relative value scale based primarily on insurers' views of services benefits, appropriateness for subscribers, risks, efficacy, and spillover implications for other services and costs; and

(3) conversion of the relative value scale into a fee schedule.

A key issue in the establishment of a fee schedule is the payment unit determination. If separately identifiable payments continued to be made for each individual service, the existing incentives for unbundling, code creep, and volume and complexity increases would remain. It may be possible to counter these incentives by defining frequently provided services more precisely and aggregating certain services into larger more comprehensive units. However, it is not clear what services should be included in these larger packages, particularly for ambulatory care.

A second set of issues relates to the initial level at which fees are established. Implementation of a uniform payment amount would mean that some persons would receive higher payments and some would receive lower payments than they would under the current system. If desired, this effect

could be partially offset through a phase-in approach though this could result in higher overall expenditures.

It is expected that a fee schedule would be established with a certain target budget amount in mind. The conversion factor therefore would need to be calculated to reflect projections of volume, unbundling and other changes.

A third set of issues relates to the differentials, if any, which would be permitted by specialty, setting where the services are rendered, or geographic area. A nationwide fee schedule could increase fees to non-Medicare patients in areas where the Medicare fees would be higher than those being billed by local physicians. In areas where the Medicare fees would be far below the previously recognized prevailing levels, physicians would be less apt to accept assignment. The beneficiary then would be expected to pay fees significantly in excess of Medicare's reimbursement levels.

Theoretically, the fee schedule could be designed in such a way as to alter certain economic incentives in the current system. For example, the multiplier amount might be increased for medical visit procedures and lowered for surgical procedures.

The fee schedule amounts might be established on a competitive basis. Doctors could bid proposed conversion factors to Medicare with the program accepting a certain percentage of the bids. For those whose bids were not accepted, beneficiary cost-sharing might be higher. Additional incentives might be included for participating physicians.

B. Physician DRGs

The Social Security Amendments of 1983 (P.L. 98-21) provided for the establishment of a prospective payment system (PPS) for inpatient hospital services based on diagnosis related groups (DRGs). The legislation also required

the Secretary to report to Congress in 1985 on the advisability and feasibility of paying for physicians' services provided to hospital inpatients on the basis of a DRG-type classification system. The report was due July 1, 1985, but had not been forwarded to the Congress as of November 1, 1985.

It was expected that a physician DRG payment scheme for inpatient services would involve the establishment of a predetermined rate for each of the 468 DRGs used under the PPS system. The rate could be based on the average of allowable charges per admission during a base year. Rates which appeared out-of-line might be repriced, vis-a-vis rates for other services. Census division and urban/rural variations comparable to those under PPS might be included.

Physician DRG payments would provide a single predetermined payment for all physicians' services (whether provided by one or more physicians) rendered during the inpatient stay. The payment unit is generally thought of as starting with the hospital admission and ending with the hospital discharge. It would thus be consistent with the PPS unit of service which is the hospital stay. In some cases, e.g., certain surgical DRGs, the pricing package might be defined to include certain preadmission and/or post discharge services or time periods of services. This would counter incentives to unbundle some services; that is, to perform some services that are currently rendered during the inpatient stay either before or after the hospital stay such that they can be billed as separate services. However, for many DRGs, particularly nonsurgical DRGs, it would be difficult to define what preadmission and/or post discharge time period or services should be considered part of the inpatient episode for reimbursement purposes.

There is some concern that the existing DRG classification system which was designed to reflect hospital costs may not fully reflect differences in physician input costs. One approach to evaluating how well the DRG classification

captures differences among patients in physician-related treatment costs is to compare what physician payments would be under a DRG approach to those made under the current system. If current payments are relatively consistent within a DRG, then the hospital-based DRG classification might be viewed as a reasonable means of classifying patients for physician payments. A recent study by Janet Mitchell 6/ showed that while there is relatively little variation in the cost of total physician services within many surgical DRGs, there were wide variations in such costs within medical DRGs. There are several possible explanations of this finding. One may be that the attending physician in a particular medical DRG may represent one of a number of specialties while the attending physician in a surgical DRG is generally representative of a single specialty. Another explanation may be the fact that the degree to which physician involvement is fixed or nondiscretionary is higher for surgical than for medical DRGs. The treatment for some medical cases simply may be less well defined than for surgical cases. For example, the treatment of a surgical case almost always involves both a surgeon and an anesthesiologist whereas the attending physician for a medical case may have many options including which diagnostic tests to order and whether or not to use other physicians as consultants on the case.

This study found that making payments on the basis of physician DRGs could thus result in inequitable losses for some physicians and windfall gains for others. Potential gains and losses were also found to be associated with physician specialty. General practitioners would gain on the average because they generally have lower fees than specialists admitting patients in the same DRG.

6/ Mitchell, Janet. Physician DRGs. New England Journal of Medicine, Vol. 313, n. 11, September 12, 1985, p. 670-675.

Ophthalmologists generally would gain because they control their area of specialization while thoracic surgeons frequently would lose because they perform substantial amounts of less complex surgery for which there is a moderately large amount of fee competition from less highly trained specialists. Differences among winners and losers may also occur because of differences in practice styles (e.g., whether or not an assistant surgeon is used during cataract surgery) and the triaging of more seriously ill patients within a given DRG to certain specialties. As a result of the findings of this study, a number of persons have suggested that it might be appropriate, at least in the initial implementation stages, to limit a DRG payment system to inpatient surgical procedures.

One of the key issues in designing a physician DRG payment system is determining to whom the payment actually should be made. Payments could be made to the attending or admitting physician, the medical staff of the hospital or the hospital itself. One consideration in making this choice is the degree of financial risk that is imposed on the various parties involved. For example, an individual physician's caseload may consist of a higher proportion of sicker patients within a DRG category, requiring more intensive care than the average for that DRG. Placing an individual physician at risk potentially could encourage the provision of less care than was medically appropriate or the avoidance of more severe cases. Further, this approach would impose additional administrative burdens on physicians. If the payment were made to the attending physician, he would be responsible for obtaining requisite services from other physicians and paying them for services rendered. Problems could arise if physicians could not agree on how to subdivide the single payment.

Alternatively, physician DRG payments could be made to the medical staff of the hospital which would then be responsible for distributing the payments.

It has been suggested that the distribution of payments among individual physicians could be based on their percentage of total billings. If total billings exceeded DRG payment amounts, each staff member would receive proportionately less, while if total billings were less than payments, each staff member would receive proportionately more. Thus, the physicians collectively would be at risk for either excessive utilization or excessive billings by individual members. This approach is similar to the method used by some health maintenance organizations (HMOs) to reimburse their member physicians. While placing additional burdens on hospital staffs, this approach would have the potential advantage of creating a risk pool of sufficient size to avoid unacceptable risks associated with increases in case severity (i.e., increase in the percentage of sicker patients requiring more care than average for a particular DRG).

Another approach would be to pay the hospital directly which would in turn distribute the funds. Payments could be made either as a separate physician DRG payment or as a combined amount for both physicians' and hospital services rendered during the inpatient stay. This approach places strong incentives on the hospital to contain expenditures. However, it would place the institution in the position of arbitrating payment disputes among physicians and, in the case of combined payments, among physicians and its own competing interests.

A physician DRG payment system would give physicians (or physician groups) the incentive to practice more efficiently since they would be at risk for any costs in excess of the package price. This payment approach would directly address the problem of unbundling for services provided in the inpatient setting. It also would address the divergence of economic incentives that currently exist between hospitals and physicians. Under PPS, hospitals have the incentive to hospitalize patients for as short a period as needed and to perform a

minimum number of tests and treatments. Conversely, physicians have the incentive to keep patients in the hospital longer and to perform additional billable procedures. Implementation of a physician DRG system would align these incentives. However, the concern has been expressed that if hospital and physician incentives are too closely aligned, the quality of patient care may be affected adversely. The physician may no longer be as strong an advocate for needed medical services. Patient access to care may be affected if hospitals practice "skimming," i.e., admitting large numbers of patients who require less care than average for the DRG while referring elsewhere patients who require more care than average.

While a physician DRG payment approach would limit expenditures for individual admissions, it might not be effective in controlling overall expenditures. For example, physicians could change their practice patterns such that certain complex cases are managed in two admissions instead of one. It is also likely that many services would be transferred to outpatient settings and billed for separately.

The DRG payment limitations would not apply to services provided in outpatient settings -- roughly 35-40% of total physician expenditures. It generally has been agreed that the capability does not exist to extend the DRG approach beyond the hospital setting. DRGs for inpatients have been defined in terms of specific diagnoses which require comparable resources and are delimited by the hospital episode itself. However, identification of payment units for purposes of outpatient services is more difficult.

A recent study 7/ explored the possibility of creating a DRG-like classification scheme for categorizing outpatient visits. This classification,

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7/ Fetter, Robert, et. al. Ambulatory Visit Groups: A Framework for Measuring Productivity in Ambulatory Care. Health Services Research, Vol. 19, No. 4, October 1984, p. 415-437.

known as Ambulatory Visit Groups (AVGs), seeks to create homogeneous types of patient visits based on the presenting problem, principal diagnosis, patient's age, visit status (old or new patient with old or new problem), and other factors. An analysis of 1976 data resulted in the formation of 154 AGVs. This research is being extended to explore the use of AVGs for paying physicians for ambulatory services.

Using AVGs as the payment unit for ambulatory care has many of the same advantages and disadvantages as the use of DRGs as the basis for paying hospitals for inpatient services. Services are bundled into larger units of payment, removing the incentives for over-utilization within the individual payment unit. As in the case of hospitals, the bundling could lead to under-utilization of medically necessary services. As with hospitals which can increase their revenues under PPS by increasing their admissions, physicians could increase their incomes under an AVG reimbursement system by increasing the number of visits per patient. Therefore, implementation of an AVG reimbursement system would probably have to include provisions for quality and utilization reviews.

C. Capitation

A third reform option is capitation. Under a capitation system, Medicare would pay an organization, (either a provider or insurance company), a set monthly fee, or capitation amount, for each Medicare beneficiary covered under the capitation contract. In return, the organization receiving the payment would be responsible for financing the care of the covered beneficiaries, including, but not limited to, that provided by physicians. A capitation payment is similar to an insurance premium. In essence, Medicare would purchase health insurance for its beneficiaries providing a specified scope of benefits.

At the same time, the risks associated with providing these benefits would be transferred from Medicare to the "insuring" organization.

A capitation system incorporates financial incentives that differ from those of a fee-for-service system. Under a capitation system, the organization receiving the capitation payments bears the financial risks of overutilization and inefficiency. Thus, these entities have financial incentives to control utilization (through case-management and utilization review) and to develop cost-effective patterns of care. However, if these incentives are too strong (such as if the capitation amounts are too low), they could lead to underutilization and a decline in the overall quality of care.

Two general approaches to a capitation system have been suggested. The first is to make capitation payments to provider organizations, such as Health Maintenance Organzations (HMOs) or Competitive Medical Plans (CMPs). The second is to contract with entities, such as insurance companies, that would then serve as "at-risk" insurers for all beneficiaries residing within defined geographic areas.

Medicare currently pays some providers (risk-contracting HMOs and CMPs) on a capitation basis. Qualifying HMO/CMPs can enroll Medicare beneficiaries. For each enrolling member, the HMO/CMP is paid a monthly capitation amount equal to 95 percent of an amount known as the Adjusted Average Per Capita Cost (AAPCC). The AAPCC is an estimate of the expected cost to Medicare if the beneficiary had not enrolled in the HMO/CMP. The AAPCC levels take into account geographic differences in the cost of providing care, and certain characteristics of the enrolling beneficiaries (age, sex, whether institutionalized and whether eligible for Medicaid). Under current law, participating HMO/CMPs are financially responsible for all Medicare benefits, either both Part A and B benefits or Part B benefits only, depending on whether or not the enrollee is eligible

for both Parts. Enrolling beneficiaries are "locked-in" to the plans they join. That is, beneficiaries are liable for the cost of any non-emergency care they receive outside of the HMO/CMP without prior authorization from the plan.

It is predicted that the number of Medicare beneficiaries who are covered under these arrangements will grow substantially over the next few years. As of June, 1984, there were about 200,000 beneficiaries enrolled in risk-contracting HMO/CMPs under demonstration contracts. HCFA expects this number to increase by as many as 600,000 beneficiaries over the next 3 years. In spite of this growth, beneficiaries covered under capitation contracts will still represent only a small fraction of the Medicare population. Even if this program's growth could be accelerated, it appears unlikely HMO/CMP enrollees would represent a majority of Medicare beneficiaries in the near future.

Under an alternative proposal, Medicare could contract with an entity, such as a carrier or insurer, that would serve as an at-risk insurer for all Medicare beneficiaries residing in a defined geographic area. This type of plan is sometimes referred to as a geographic capitation system. Medicare would essentially purchase a specified package of benefits for a specified capitation amount. The capitation amount could be based on the AAPCC as currently used for paying risk-contracting HMO/CMPs. Alternatively, the capitation amount could be determined by allowing potential carriers to bid or negotiate a set price. The entities would be responsible for determining provider payment amounts and payment units. These entities could also be allowed, and/or encouraged, to make use of HMOs and CMPs, where such organizations exist. To assure beneficiary access to care, the contracting organizations could be required to obtain physician participation agreements from a certain percentage of providers in the area.

There is relatively little experience with the concept of geographic capitation systems. The State of Texas has contracted on a capitation basis with a private insurer to provide acute care benefits under its Medicaid program. The State maintains control over eligibility and payment amounts while the insurer provides claims processing and utilization review services. The contract also provides for a sharing of risk between the State and the insurer.

Recently, Blue Cross/Blue Shield of Maryland proposed a variation of a geographic capitation system as a Medicare demonstration project. This proposal would offer Medicare beneficiaries in certain Maryland counties three options:

(1) continuation of existing Medicare program benefits;

(2) enrollment in an HMO; or

(3) enrollment in a Preferred Provider Organization (an organization of providers who continue to bill on a fee-for-service basis but who agree to bill discounted fees and to participate in the plan's utilization control programs).

A potential drawback of geographic capitation systems, and to a lesser extent certain types of HMOs, is that they do not necessarily change how physicians are paid. While Medicare's payments to the insuring organizations would be capitated, payments from the insurers to providers could retain the current mix of fee-for-service and capitation through established HMO/CMPs. The capitation limit would provide the insurers with incentives to implement effective utilization review programs and to develop new programs (such as PPOs) to encourage the use of low-cost providers. However, to the extent that physicians continued to be paid on a fee-for-service basis, many of the current problems (code-creep, unbundling, and incentives for over-utilization) could remain.

A second problem with capitation systems is determining the appropriate level of the capitation payments. Medicare currently pays risk-contracting HMO/CMPs 95 percent of the AAPCC. Similar calculations could be made for other

types of capitation systems. However, many persons feel that the AAPCC does not adequately reflect variations in the health status of enrolled populations. If capitated plans are permited to compete, such as two HMOs with similar service areas or a capitated plan with traditional Medicare, failure of the AAPCC to reflect enrollees' health status accurately could result in overpayments to some plans and underpayments to others. If all Medicare beneficiaries in a geographic area are assigned to a particular carrier or HMO (i.e. making the capitated system mandatory), there would be less concern regarding how accurately the AAPCC reflects variations in health status. This is due to the fact that, over a large geographically designed population, average utilization and costs, and thus average AAPCC payments, would be relatively stable and predictable. However, a mandatory capitation system would create other problems. For example, the current methodology for estimating the AAPCC uses claims data for non-capitated Medicare beneficiaries. With mandatory capitation, this source of data would disappear. Without current data, it could be difficult to update the AAPCC amounts after the capitation system was fully implemented.

D. Assignment/Participation Issues

Regardless of the reform option chosen, the issues related to assignment would need to be examined. Should physicians be required to accept Medicare's payment rate as the full payment (plus any required coinsurance) or should they be permitted to charge additional amounts? That is, should assignment be mandatory or optional? The issue of mandatory versus voluntary assignment has been the focus of debate for several years. The American Medical Association (AMA) is strongly opposed to mandatory assignment while a number of beneficiary groups have indicated their support.

Proponents of mandatory assignment note that under the current system, a number of beneficiaries have been faced with high and in some cases unanticipated out-of-pocket costs in connection with their doctors' bills. In FY84, beneficiaries effectively faced a coinsurance of 43.6 percent on unassigned claims; they were financially responsible for the 23.6 percent average reduction from billed charges in addition to the 20% statutory coinsurance amount. In many cases these out-of-pocket expenses were not anticipated because of beneficiary misunderstandings of the complex Medicare payment system. Even if they are anticipated, it may be difficult for many beneficiaries to budget for the reduction amounts associated with unassigned claims. Frequently, these amounts are not covered under health insurance policies supplemental to Medicare (so-called "Medi-Gap" policies).

Proponents of mandatory assignment suggest that the existing problems will be exacerbated if Medicare places additional limits on approved charges. They suggest that physicians may be less likely to accept assignment and that Medicare cost-savings will be transferred to beneficiaries in the form of increased out-of-pocket costs for unassigned claims. In addition, any incentives for efficiency that are incorporated in a new payment system could be largely offset unless assignment were mandated. It has been suggested that mandatory assignment would be particularly important under a physician DRG payment system. Otherwise, physicians could accept assignment for cases whose costs were less than the DRG rate and not accept assignment and bill the patient the additional amount when the costs were more.

Mandatory assignment would, in effect, limit overall payments for covered services provided to enrollees. Opponents of this approach contend that mandatory assignment would represent an unwarranted infringement into the private practice of medicine. It would interfere with the existing doctor-patient

relationship by preventing physicians from freely entering into "contracts" with their patients. Advocates of the voluntary assignment approach state that since physicians currently have the option of accepting or rejecting assignment, Medicare beneficiaries are able to select from virtually the entire physician population. They argue that if assignment were mandated, a number of physicians might drop out of the program. Beneficiary access in certain geographic areas and/or to certain physician specialities would therefore be jeopardized. Patients who have established long-standing relationships with particular physicians might be forced to seek care elsewhere if they wished to receive program payments for services. Advocates of mandatory assignment have countered this argument by stating that the developing oversupply of physicians coupled with the importance of Medicare revenues in many physicians' practices make a significant access problem unlikely in most areas.

Opponents of mandatory assignment indicate that physicians as a group have been responsive to the financial concerns of their patients. Physicians are more willing to accept assignment in cases of financial hardship and are more likely to accept assignment as annual charges increase and as beneficiaries get older. They also note that the majority of beneficiaries have relatively modest annual liability in connection with physicians' claims.

V. CONGRESSIONALLY MANDATED STUDIES

A number of entities, both governmental and private, are studying various aspects of physician reimbursement under Medicare.

The 97th Congress required the Department to prepare the following two studies which were due in 1985:

1. Physician DRG Study. P.L. 98-21, the Social Security Amendments of 1983, established the prospective payment system for hospitals based on DRGs. This legislation also required the Secretary to begin during FY84 the collection of data necessary to compute the amount of physician charges for services furnished to hospital inpatients for each DRG. The law required the Secretary to report to Congress in 1985 on the advisability and feasibility of paying for inpatient physicians' services on the basis of DRGs. P.L. 98-369 specified that the due date was July 1, 1985. This report had not been submitted as of November 15, 1985.

2. Study of Change in Volume and Mix of Services. P.L. 98-369 required the Secretary to monitor physicians' services to determine any change during the 15-month fee freeze in the per capita volume and mix of services provided to enrollees. The Secretary was required to report to the Congress by July 1985 on any changes that had occurred. The report was to include legislative recommendations for assuring that any restrictions in the growth of Part B costs which Congress intends to be borne by providers and physicians is not transferred to beneficiaries in the form of increased out-of-pocket costs, reduced services or reduced access to needed physicians' care. This report had not been submitted as of November 15, 1985.

The Department is conducting a series of studies on a broad range of physician reimbursement issues both in connection with the congressionally mandated reports as well as its ongoing interest in these issues. While some of these studies have been completed, the results have not yet been released by the

Department. It is anticipated that the findings will be included as part of the Congressionally-mandated reports.

P.L. 98-369 also required the Office of Technology Assessment (OTA) to report to Congress by Dec. 31, 1985, on findings and recommendations with respect to which Part B payment amounts and policies may be modified to:

--eliminate inequities in the relative amounts paid to physicians by type of service, locality and specialty with attention to any inequities between cognitive services and medical procedures; and

--increase incentives for physicians and suppliers to accept assignment.

The report is to include information on methodologies which could be applied, consistent with the study's findings, in the development of fee schedules on a National or regional basis. The Secretary is required to review the OTA report and provide comments and recommendations to the Congress.

STATEMENT OF SENATOR DAVE DURENBERGER

This past April the HMO Competitive Medical Plan option was made available to Medicare beneficiaries. This reform process will lead Medicare out of the insurance business as it provides Medicare beneficiaries with a premium subsidy which they can use to buy a health plan of their choice. The federal government's role will then be comparable to that of an employer, who offers his employees a set of health plans to choose from and assumes an active interest in the quality and the mix of services provided by the health plans it offers.

This goal will not be reached tomorrow. Reform is by nature incremental. In the transition, reform has taken a parallel track. This track features prospective payment for services and it has concentrated on Part A, inpatient hospital services.

The Senate has proposed in its Reconciliation package expanding the prospective payment system to include outpatient surgery.

This would be the first effort to reform Part B since its creation in 1965 based on Blue Shield and Aetna outpatient and physician's plans models.

Today's hearing will examine recommended alternative payment systems for physicians—the largest part of a rapidly growing Part B expenditure.

We are fortunate today to have the benefit of testimony from most of the best qualified persons in this country. Representing providers, insurers and beneficiaries, they will provide us a look at our opportunities from every possible angle.

We begin with one common ground from which all witnesses launch their testimony: the present physician reimbursement system is complex, unfair, inefficient and must be changed. Prospective payment changes for hospital inpatient services have increased both need and opportunity for change. Here are some current problems:

First, there are tremendous regional variations in "reasonable charges" as determined under Medicare. Differences in fees across this vast nation are to be expected. But, there is no reason that the average prevailing rate for by-pass surgery in Manhattan should be 100% more than in the Twin Cities.

Second, there is little or no incentive for prices to change as practice patterns change. Physicians' charges are set high for new procedures. When efficiency is gained through improvements in technology, or when formerly complicated or high risk procedures become routine, the change is not reflected in lower fees.

This is true with cataract surgery, for example, a procedure which has changed dramatically over the last seven years. The procedure used to take hours, now it can be done without general anesthesia, at much less risk in a matter of 25 minutes. And there are many other examples.

Third, there is a considerable variation between what Medicare pays general practitioners versus specialists for virtually identical services. There is evidence to indicate that Medicare may not always be paying for higher quality care, or a truly different product, but the bias remains towards paying the specialists' higher fees.

Fourth, there are significant variations between the fees paid for hospital visits versus office visits, variations which are not always appropriate. In some areas of the country follow-up hospital visits can cost 25% more than those in an office.

Finally, under the current system the physicians actually doing the procedures are rewarded disproportionately to those spending time with the patients for examination and counsel. The incentives are for the physician to act, by the numbers rather than thinking through the possibilities.

Beyond this set of concerns, the so-called "reasonable and customary" system Medicare uses is simply too complicated and difficult for physicians, let alone beneficiaries, to understand.

The alternative payment systems we will discuss today include: refinement of the current system; payment based on fee schedules; and payment for packages of services. There are many options within each of these models. The subcommittee is open to alternatives at this point and will be looking to the experts for their advice and suggestions.

Before I introduce our first witness, I am compelled to express a concern which all of us in this room must share as we meet here today. Reform of this nation's health care system is being pushed to the back of the bus by the rowdies more concerned about the budget policy. Despite the fact that Medicare has contributed more than $30 billion dollars to deficit reduction over the last four years and will be cut further when we do the Reconciliation package, it remains vulnerable to further cuts.

While national defense spending has doubled, national debt service has tripled, and income tax revenues have been held static, the beneficiaries and the providers through reform of Medicare will give—and have given—the federal government and private health payers real dollar savings with which to finance all this other spending increase and tax decrease. If we freeze reform, the quality of health care for

Medicare beneficiaries in America, as well as, access to that health care will surely die of frost bite.

Costs for physicians have increased substantially, especially through outrageous professional liability premiums. Who would blame some if they forsake Medicare beneficiaries? Rural health care is facing a real crisis; and inner city hospital service to a fast-growing under-insured population are not being financed at all adequately.

The American public, particularly the elderly and the disabled deserve the best medical care available. It will be "penny wise and pound foolish" to cut too deeply today, or to disrupt the process of health system reform which I am confident will make this nation's health care system more cost effective and of higher quality.

Opening Statement of Senator Bob Dole

Mr. Chairman, our job today is a particularly critical one. The purpose of the Medicare Program is to provide our elderly and disabled citizens with financial protection against the cost of medical care. While there are many key players in the program, the physician remains the team leader and coordinator of our health care delivery. We are here today to discover the status of the Medicare physician payment system, what works and what does not work, and to begin to figure out what we can do to get us headed in the right direction.

Nobody is happy with the current system of physician payment. Physicians and beneficiaries need to know what will and what will not be covered, and we all need to know what it is we are really buying and at what price. The system should be fair, equitable, monitorable, supported by appropriate incentives, and, although this may be asking too much, it should be understandable to everyone.

In the Deficit Reduction Act of 1984, we envisioned the 15-month physician fee freeze as a temporary fix for rapidly escalating costs that threatened the future of the program. Even now, we can count on another year of that freeze. Frankly, viable alternatives for the short run were unavailable, and we knew better than to make major changes precipitously. We must still keep that in mind as we prepare to move forward. We did, however, deliver a clear message in 1984. We wanted answers.

Several major studies have been undertaken that should help light our way. I trust we will now gain the benefits of those inquiries. I am particularly concerned that these studies and any future planned demonstrations provide us information that can be used to study a number of options for reform—not simply give us one answer and nothing to compare it to. However, I am beginning to sense that someone may have decided what the answer should be and is bound and determined to give us only information that will foster this case. I would hope today's testimony will prove me wrong.

As I noted earlier, it seems that an interest in changing the system can be found among all parties to the system; consumers, physicians, other providers, and Medicare. We should be able to begin the reforms sooner, rather than later. It's already later than many of us would like. Physicians and beneficiaries deserve to know that we are trying to do more than simply force a 3rd year of the freeze because of the absence of anything else to do.

I welcome the witnesses, and I look forward to the information and guidance you will share with us. You represent a broad range of expertise and interests. Some of you are reimbursement experts, others are purchasers, providers and beneficiaries of physician services. In this area of physician payment reform, you are all essential, and we need your help and your support to achieve a workable solution.

Medicare beneficiaries must continue to have access to quality health care services both now and in the future. And the providers that have so willingly worked with us in the past, deserve to be treated fairly and equitably. We absolutely cannot achieve that goal with a system that does not adapt to meet the needs of our changing health care environment.

Thank you Mr. Chairman for holding this hearing.

Senator DURENBERGER. The hearing will come to order.

Good morning, everyone. The Chair is going to save his opening statement for whenever it arrives. [Laughter.]

Senator DURENBERGER. I thought I did a great job on it last night, and my staff brought me down this morning, so maybe Max can use some time on a brilliant opening statement. If not, I am

going to introduce Henry, then Vita is right after Henry, and then we go to some of our panels.

On our first panel, Keven Fickenscher, who represents a constituency terribly important to Max and myself and lots of other people—the Rural Health Care Association—has an airplane problem; so he will speak first on that panel. Otherwise, everything is as printed.

Max, do you have an opening comment?

Senator BAUCUS. None, Mr. Chairman.

Senator DURENBERGER. All right. Let us begin, then, with Dr. Henry Desmarais. Welcome back; we appreciate your coming. It is often nice to have somebody representing the administration who has an administration view on things, but we haven't had that lately. That is all right, because we know you have been around a long time, and we know you are good, and we know that HCFA has done a lot of things on some of these health policy issues including this one. So, we welcome your testimony, and your full statement will be part of the record.

STATEMENT OF HENRY R. DESMARAIS, M.D., ACTING DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Dr. DESMARAIS. Thank you, Mr. Chairman.

I have with me this morning Carol Kelly, the Acting Associate Administrator for Policy, and Dr. Allen Dobson, the Director of HCFA's Office of Research.

We are here today to talk about physician reimbursement under Medicare and the available reform options. As you know, the current system is one that is predicated on customary, prevailing and reasonable charges. Essentially, those are charges from one period which our contractors subject to a series of calculations. They are then used to set customary charges for each service performed by each physician, and prevailing charges for each type of service rendered in an area.

When Medicare was enacted by the Congress back in the midsixties, great deference was given to the local billing situation and charging practices of physicians. As a result, there was a great lack of uniformity across the country; in some places each State is a single locality, so there is a single prevailing charge in that whole State for a particular service. Other States have multiple localities; and, in fact, in Texas we have 32 localities.

That kind of lack of uniformity also applies to the way specialties are treated. Some States have no specialty differentials; so, no matter who performs the service, the same prevailing charge applies. In other places, there are specialty differentials. Furthermore, the definition of what is a specialty varies across the country.

Suffice it to say that this customary, prevailing and reasonable charge system has been criticized by a number of thoughtful bodies: the Advisory Council on Social Security, the Grace Commission, and so on. These criticisms include the fact that the system is inflationary, that it is confusing, that it is biased in favor of high technology procedures instead of primary care, that it is biased in

favor of inpatient over ambulatory care, biased in favor of urban practice settings instead of rural, and, finally, biased in favor of specialists over generalists.

Over the 10-year period which ended in fiscal year 1983 we know that Medicare spending for physician services averaged an annual rate of increase of about 20 percent.

In 1984, Congress decided that the Deficit Reduction Act provisions were an appropriate response to these increases. The act created a participating physician program, froze the Medicare prevailing and customary charges for all physicians, and, as well, froze the actual charges of nonparticipating physicians. We should remember that these price freezes are just that—they are freezes applied to prices, not utilization and not to mix or intensity of services. And that certainly is important.

We believe that the freeze had a significant impact. In fact, when we look at fiscal year 1985 we believe that the rate of increase, instead of the usual 20 percent annual rate, was somewhere in the neighborhood of 11 to 12 percent.

Senator DURENBERGER. Do you attribute that to the freeze?

Dr. DESMARAIS. Not solely to the freeze, no, sir. We had the impact of prospective payment in hospitals which decreased length of stay and decreased the use of ancillary services, all of which have a physician component to them as well. There was lots going on in the system—HMO's, competitive medical plans, and so on. So, no, not solely to the freeze.

Senator DURENBERGER. But you don't have any sort of a scientific study that says "so much is attributable to freeze," so we can prove freezes are good, and so much is attributable to that?

Dr. DESMARAIS. I don't think we will ever be able to have that kind of determination. But we do have additional work ongoing with respect to what was physicians' response to the freeze. That is a several-year project that has been started by one of our contractors.

One of the positive outcomes of the decreased rate of increase was the Secretary's ability to announce that the part B monthly premium would remain at $15.50 for one more year, a very unusual development. Normally we announce increases in the monthly part B premium. We were able to avoid that this year. And along with that, of course, there would be less cost sharing for our beneficiaries if the Medicare-allowed charges were lower.

However, despite the good news, there still is a problem. The physician component of the CPI is still growing faster than the overall CPI; in 1985 it was 6 percent on the physician component versus 3.2 percent overall.

Of course, you would be the first to agree that a freeze is not reform. As I pointed out earlier, the freeze provides no control over utilization and intensity. So we do need to march along and think of other alternatives.

Congress mandated that we examine alternatives, and the congressional mandate was rather specific: it said to report back on the advisability and feasibility of using DRG's to pay for inpatient physician services. Approaching that task, we determined immediately that we would not confine ourselves solely to a study of that

question, but we would incorporate into the study other alternatives as well. This is what I am here to report on.

The report itself is in the final stages of review. We hope to transmit it to the Congress in the near future.

Senator DURENBERGER. That is a phrase we ought to encapsulate in some way: It is in the final stages of review. Very good. And we promise it in the near future. [Laughter.]

Dr. DESMARAIS. The three options which are discussed in the report are the following: The physician DRG's; the use of fee schedules and/or refinements in the current, customary, prevailing and reasonable charge system; and, third, capitation. I would like to discuss each of these options in some detail and give you our thoughts at this time.

The first is DRG's. This would obviously be a prospective payment per discharge for inpatient physician services that are associated with each of the hospital DRG's. We did a great deal of work inhouse, and we also had a number of contractors work for us on the whole issue of DRG's and their suitability. And many of those contractors are here at your invitation this morning. Their report back to us was that DRG's did a reasonable job of explaining the variability of cost-per-case, but much of that was due to the fact that surgical cases were more predictable than medical cases.

As we looked at the whole issue, we determined that one of the difficult questions to settle in a DRG system for physicians would be the question of whom to pay. There seem to be three possible alternatives—paying the hospital, paying the attending physician, or paying the medical staff as a whole.

Paying the hospital would be an administrative burden on hospitals and would probably strain the hospital-physician relationship. Paying the attending physician is difficult because most attending physicians see only a few dozen Medicare patients during the course of a year and, as a result of the variability in the cases, would face a level of risk, that would be unacceptable for any single individual physician to assume.

While paying the medical staff would solve the risk-pooling problem, we're not sure that it would work. It has not been done before, essentially, in any major way, and it is unclear whether the medical staff could organize to handle this kind of situation.

The other observation we should make in distinguishing the physician DRG issue from the hospital DRG issue is the question of assignment. As you know, hospitals cannot extra-bill beneficiaries. So, the DRG payment is a great incentive toward efficiency. Under current policy, non-participating physicians have the option of taking assignment on a case-by-case basis. If that were to stay in place, the incentive, for efficiency would be diluted somewhat because they could in turn extra-bill the beneficiary if they chose to.

I want to be very clear here that by making this observation, I am not in any way encouraging a move toward mandatory assignment. This Administration remains steadfastly opposed to mandatory assignment, and we believe that market forces and the growing supply of physicians are really a better course of action regulatory schemes.

We also need to observe that, even if we use DRG's, we would only be covering about 60 percent of physicians services. In fact,

that percentage seems to be dropping as more and more is moved to the outpatient and ambulatory side of the equation.

Suffice it to say that the DRG's approach seems to have serious policy and implementation problems.

The second major option is the use of fee schedules, which would set a maximum allowable charge for each procedure. One way of doing this would be to use a relative-value scale, where each service would get a weight—the higher the weight, the higher the value, the higher the payment that would be made. We have about 7,500 described physician services at this point in time.

There are two approaches here for relative values: one is charge-based, simply taking historic charges and arraying them to come up with relative values. Of course, that maintains the current built-in biases. Another approach is the resource-based way of constructing a relative-value scale; value meaning time, risk, value to patient, value to society, training costs, and so on.

A fee schedule might be a simplification, but it does have some serious handicaps: again, no control over utilization and intensity, and limited additional control over the price component of the problem.

As I have said, the charge-based approach is biased, and a resource-based relative value scale we feel would be a long, very difficult and less than objective process to create—that is sitting down with panels of expert physicians and other groups to try to decide what the value of each of those physician services is. And of course, finally, it is an inherently regulatory approach.

The third option, and the one we prefer, is the capitation option, because it addresses both price and utilization/intensity; and payment would be made for all physician services and, in fact, all services during a period of time.

We are already well on our way on the road to capitation as the result of the Tax Equity and Fiscal Responsibility Act, which for the first time gave us true risk-sharing HMO's and competitive medical plan contracts.

We have 78 of those contracts now, covering about 400,000 of our beneficiaries, and other risk contracts such as demonstrations bring us to a total of 460,000 beneficiaries now being served by risk-based HMO's and CMP's. And we hope that 1.4 million of our beneficiaries would be so served by fiscal year 1987.

We are also moving in other directions in capitation. A voucher proposal is on the table. This would be voluntary for beneficiaries and would expand the entities that can get these kinds of capitated payments. Beyond the HMO's and CMP's we would add indemnity insurors. We also propose to add additional flexibility, so that there could be some benefit restructuring, there could be cost-sharing restructuring, and a variety of other things.

In addition, we have a lot of research underway to foster capitation—improving the way we pay HMO's and CMP's today by refining the payment mechanism, the average adjusted per-capita cost, AAPCC, trying, for example, to perhaps adjust for prior use or severity of illness and so on.

We also are discussing other alternatives such as geographic capitation and employer-at-risk.

In conclusion, capitation is our goal with respect to physician payment, and it will be the focus of our attention and our energy, because we believe that this is the way to consumer choice and competition. It is deregulatory, and it will deal with price as well as utilization and intensity.

In the meantime, we plan to examine appropriate ways to refine the current CPR system. Examples of such refinements could be correcting for overpriced procedures and seeing whether locality and specialty differentials remain appropriate.

I would be happy to stop here and take your questions.

[Dr. Desmarais's written testimony follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C.

STATEMENT OF

HENRY DESMARAIS, M.D.

ACTING DEPUTY ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH
FINANCE COMMITTEE

UNITED STATES SENATE

DECEMBER 6, 1985

I AM PLEASED TO BE HERE TODAY TO DISCUSS OUR EFFORTS TO DEVELOP OPTIONS FOR PHYSICIAN PAYMENT REFORM UNDER THE MEDICARE PROGRAM.

THE CURRENT SYSTEM DEMANDS REFORM BECAUSE IT DOES NOT PROVIDE THE INCENTIVES REQUIRED TO CONSTRAIN SPENDING AND ASSURE APPROPRIATE UTILIZATION OF SERVICES. WE HAVE EXPLORED VARIOUS OPTIONS FOR REFORM OVER THE PAST FEW YEARS, THROUGH RESEARCH EFFORTS AND INTENSIVE DISCUSSIONS BOTH WITHIN THE ADMINISTRATION AND WITH REPRESENTATIVES OF THE MEDICAL COMMUNITY. THREE MAJOR STRATEGIES HAVE EMERGED.

ALTHOUGH THERE ARE ASPECTS OF TWO OF THESE APPROACHES -- FEE SCHEDULES AND DRG-BASED PAYMENT -- THAT MIGHT MAKE EITHER AN IMPROVEMENT OVER THE CURRENT SYTEM, BOTH APPROACHES HAVE SERIOUS DRAWBACKS. CAPITATION IS THE ONLY OPTION THAT ADDRESSES BOTH THE PRICE AND THE UTILIZATION OF SERVICES WHILE STILL PROVIDING QUALITY CARE.

IN THE SHORT TERM, IN ORDER BOTH TO ADDRESS SOME OF THE PROBLEMS WITH THE CURRENT SYSTEM AND TO MAINTAIN CONSTRAINT OVER EXPENDITURES, WE ARE CONSIDERING SYSTEM REFINEMENTS. HOWEVER, IT IS ONLY THROUGH THE CONTINUED GROWTH OF HMOS AND CMPS, THE INTRODUCTION OF MEDICARE VOUCHERS AND THE DEVELOPMENT OF NEW APPROACHES TO CAPITATION, CONSUMER CHOICE AND COMPETITION THAT WE CAN ACHIEVE MEANINGFUL SYSTEM REFORM.

BACKGROUND

MEDICARE'S METHODOLOGY FOR PHYSICIAN PAYMENT, REFERRED TO AS CUSTOMARY, PREVAILING AND REASONABLE (CPR), WAS DESIGNED TO CONFORM TO EXISTING PRACTICES IN PRIVATE HEALTH INSURANCE AT THE TIME OF MEDICARE'S ENACTMENT. UNDER CPR, MEDICARE'S PAYMENT FOR A PARTICULAR SERVICE IS CALCULATED STATISTICALLY FROM ACTUAL PHYSICIANS' BILLINGS. MEDICARE'S PAYMENT, REFERRED TO AS THE REASONABLE CHARGE, IS DEFINED AS THE LOWEST OF: THE PHYSICIANS' ACTUAL BILLED CHARGE; THE PHYSICIAN'S CUSTOMARY CHARGE (DEFINED AS THE PHYSICIAN'S MEDIAN CHARGE DURING THE PREVIOUS YEAR); AND THE PREVAILING CHARGE (DEFINED AS THE 75TH PERCENTILE OF THE CUSTOMARY CHARGES OF ALL PHYSICIANS IN AN AREA, WEIGHTED BY THE NUMBER OF TIMES EACH PHYSICIAN PERFORMS THAT SERVICE). TO RESTRAIN CONTINUED INCREASES IN MEDICARE PHYSICIAN SPENDING, CONGRESS, IN 1972, ENACTED THE "MEDICAL ECONOMIC INDEX" PROVISION WHICH LIMITS THE RATE OF INCREASE IN PREVAILING CHARGES.

THE CPR SYSTEM HAS BEEN CRITICIZED IN THE FOLLOWING WAYS.

- O REASONABLE CHARGES DO NOT DECLINE WHEN IMPROVEMENTS IN TECHNOLOGY OR SURGICAL TECHNIQUES RESULT IN A REDUCTION IN PRODUCTION COSTS.

- O CPR DOES NOT ASSURE APPROPRIATE UTILIZATION OF SERVICES.

- IT IS CONFUSING TO SOME. WHILE CUSTOMARY AND PREVAILING CHARGE INFORMATION IS AVAILABLE TO THE PUBLIC, BENEFICIARIES, AND TO A LESSER EXTENT PHYSICIANS, OFTEN DO NOT KNOW HOW MUCH MEDICARE WILL PAY FOR A GIVEN PROCEDURE UNTIL THE CARRIER ACTUALLY PAYS THE BILL.

- LIKE OTHER THIRD-PARTY PAYORS, MEDICARE'S RELATIVE CHARGE PATTERNS ARE ARGUED TO FAVOR SPECIALISTS OVER GENERALISTS, URBAN AREAS OVER RURAL AREAS, INPATIENT TREATMENT OVER AMBULATORY CARE AND SURGICAL PROCEDURES OVER PRIMARY CARE.

THE LIMITED CONTROL EXERTED BY CPR OVER THE PRICE OF SERVICES AND THE LACK OF RELIABLE CONTROLS OVER THE UTILIZATION OF SERVICES RESULTED IN A HISTORY OF RAPID GROWTH OF MEDICARE PAYMENTS FOR PHYSICIAN SERVICES.

OVER THE TEN-YEAR PERIOD ENDING IN FY 1985, MEDICARE SPENDING FOR PHYSICIAN SERVICES INCREASED AT AN AVERAGE ANNUAL RATE OF CLOSE TO 20 PERCENT. IT IS IMPORTANT TO NOTE THAT CHANGES IN THE UTILIZATION AND INTENSITY OF SERVICES -- THAT IS, THE INCREASED USE OF SERVICES AND THE USE OF MORE COMPLEX AND MORE EXPENSIVE PROCEDURES -- WERE A MAJOR FACTOR IN THIS GROWTH. IT ACCOUNTED FOR 42 PERCENT OF THE INCREASE DURING THE LATER HALF OF THE PERIOD. THUS, REFORM OPTIONS MUST ADDRESS

THEMSELVES TO BOTH UNIT PRICES AND UTILIZATION/INTENSITY IF THE GROWTH OF MEDICARE SPENDING FOR PHYSICIAN SERVICES IS TO BE SUCESSFULLY CONSTRAINED.

DURING THE SAME PERIOD THAT MEDICARE SPENDING FOR PHYSICIAN SERVICES WAS INCREASING AT 20 PERCENT A YEAR, THE FEDERAL BUDGET AND THE GROSS NATIONAL PRODUCT GREW AT ANNUAL RATE OF 12.5 PERCENT AND 9.7 PERCENT, RESPECTIVELY. CLEARLY, NEITHER THE GOVERNMENT NOR THE MEDICARE BENEFICIARIES, WHOSE PREMIUMS FINANCE 22 PERCENT OF PROGRAM OUTLAYS, COULD AFFORD THIS 20 PERCENT RATE OF GROWTH INDEFINITELY.

IN THE DEFICIT REDUCTION ACT OF 1984 (DEFRA), CONGRESS ACTED TO CONSTRAIN THIS GROWTH. ALTHOUGH SIGNIFICANT CHANGES HAD BEEN ENACTED TO THE MEDICARE PROGRAM DURING THE PREVIOUS THREE YEARS, IT WAS NOT UNTIL DEFRA THAT LEGISLATIVE CHANGES HAD A DIRECT IMPACT ON ALL PHYSICIANS.

AS PART OF DEFRA, CONGRESS ENACTED:

- A PARTICIPATING PHYSICIAN PROGRAM;
- A FREEZE ON THE CUSTOMARY AND PREVAILING CHARGES OF ALL PHYSICIANS; AND
- A FREEZE ON THE ACTUAL CHARGES OF NON-PARTICIPATING

PHYSICIANS.

IN FY 1984, DUE TO BOTH THE DROP IN ADMISSIONS AND LENGTH OF STAY RESULTING FROM THE IMPLEMENTATION OF THE HOSPITAL PROSPECTIVE PAYMENT SYSTEM AND THE IMPACT OF THE FEE FREEZE MANDATED BY DEFRA, THERE WAS SOME DECELERATION IN THE RATE OF GROWTH IN MEDICARE PAYMENTS FOR PHYSICIANS' SERVICES. THE RATE OF GROWTH IN FY 1984 WAS NEARLY HALF THAT OF THE PREVIOUS TEN YEARS AND, IN FY 1985, THIS LOWER RATE OF GROWTH CONTINUED.

NOT ONLY HAS THIS BENEFITTED THE FEDERAL BUDGET BUT IT WILL ALSO HAVE A POSITIVE IMPACT ON THE FAMILY BUDGETS OF OUR 30 MILLION ENROLLEES. BECAUSE PROGRAM OUTLAYS GREW AT A LOWER RATE THAN HAD BEEN ANTICIPATED, THE PART B PREMIUM IN 1986 WILL BE THE SAME AS THAT IN 1985. THIS IS ONE OF THE FEW TIMES THAT THE PREMIUM HAS NOT INCREASED. IN ADDITION, THE LOWER GROWTH IN PROGRAM PAYMENTS RESULTED IN SAVINGS TO BENEFICIARIES FROM COINSURANCE AND EXTRA-BILLING BEING LOWER THAN IT WOULD HAVE BEEN OTHERWISE. SOME HAVE SUGGESTED THAT ADDITIONAL FINANCIAL PROTECTION COULD BE PROVIDED TO BENEFICIARIES BY MANDATING ASSIGNMENT FOR PHYSICIAN SERVICES. THE ADMINISTRATION IS FIRMLY OPPOSED TO THIS APPROACH. WE BELIEVE THAT MARKET PLACE FORCES, INCLUDING THE GROWTH IN THE NUMBER OF PHYSICIANS AND SUBSEQUENT COMPETITION, WILL BETTER SERVE BENEFICIARY INTERESTS IN CONSTRAINING PHYSICIAN FEES

THAN WOULD REGULATORY SCHEMES.

ALTHOUGH PROGRESS HAS BEEN MADE ON REDUCING THE RATE OF GROWTH IN SPENDING FOR MEDICARE PHYSICIANS' SERVICES, THERE IS STILL CAUSE FOR CONCERN:

-- THE INCREASE IN OUTLAYS DURING FY 1985 IS LARGER THAN THE RATE OF GROWTH FOR 2/3 OF THE FUNCTIONS IN THE BUDGET;

-- ALTHOUGH THE FREEZE CONTROLLED THE PRICE OF SERVICES, GROWTH OF UTILIZATION/INTENSITY STILL REMAINS A PROBLEM;

- THE PHYSICIAN COMPONENT OF THE CPI IS STILL GROWING FASTER THAN THE OVERALL CPI. IN 1985, IT INCREASED BY 6.0 PERCENT WHILE THE OVERALL CPI INCREASE WAS 3.2 PERCENT.

THE FREEZE IS NOT PAYMENT REFORM, BUT ONLY A TEMPORARY MEASURE TO RESTRAIN SPENDING WHILE WE DETERMINE THE REFORMS THAT ARE NEEDED. PRIOR TO THE FREEZE, CONGRESS IN THE SOCIAL SECURITY AMENDMENTS OF 1983 MANDATED A STUDY ON "THE ADVISABILITY AND FEASIBILITY OF ... DETERMINING THE AMOUNT OF PAYMENTS FOR PHYSICIANS' SERVICES FURNISHED TO HOSPITAL INPATIENTS BASED ON THE DRG TYPE CLASSIFICATION OF THE DISCHARGES OF THOSE

INPATIENTS".

IN PREPARING THIS REPORT, THE DEPARTMENT DETERMINED THAT THE ADVANTAGES AND DISADVANTAGES OF A DRG-BASED PAYMENT SYSTEM SHOULD BE EVALUATED AS PART OF A REVIEW OF SEVERAL REFORM OPTIONS. THE REPORT, WHICH IS IN THE FINAL STAGES OF REVIEW WITHIN THE ADMINISTRATION ADDRESSES THREE OPTIONS FOR REFORM: PHYSICIAN DRGS, FEE SCHEDULES AND/OR MODIFICATIONS TO THE CURRENT SYSTEM, AND CAPITATION. I WOULD LIKE TO PRESENT AN OUTLINE OF EACH OF THESE OPTIONS AND THEN DESCRIBE SOME OF THE SYSTEM REFINEMENTS WE ARE CONSIDERING FOR THE SHORT-RUN.

DRG-BASED PAYMENTS FOR PHYSICIAN INPATIENT SERVICES

AN INPATIENT PHYSICIAN DRG SYSTEM WOULD SET PROSPECTIVE PAYMENTS FOR A PACKAGE OF PHYSICIANS' SERVICES ASSOCIATED WITH EACH OF THE 467 HOSPITAL DRGS. IT WOULD CONTAIN SIMILAR INCENTIVES TO CONTROL COSTS AND TO ENCOURAGE EFFICIENCY UTILIZED BY THE HOSPITAL PROSPECTIVE PAYMENT SYSTEM.
OUR RESEARCH, USING NATIONAL DATA AND DATA FROM FOUR STATES, HAS SHOWN THAT DRG'S DO A REASONABLE JOB OF EXPLAINING THE VARIABILITY IN COSTS PER CASE FOR INPATIENT PHYSICIAN SERVICES. HOWEVER, THE EXPLANATORY POWER OF DRGS AS A WHOLE IS ALMOST ENTIRELY DUE TO SURGICAL ADMISSIONS WHICH ARE ALREADY BILLED AND PAID BASED ON GLOBAL FEES. DRGS ARE NOT A GOOD PREDICTOR OF THE PHYSICIAN RESOURCES REQUIRED FOR MEDICAL ADMISSIONS BECAUSE RESOURCE USE FOR THESE ADMISSIONS IS

EXTREMELY VARIABLE. AS A RESULT, FOR MEDICAL ADMISSIONS, IT WOULD BE ABOUT EQUALLY VALID TO BASE PAYMENT ON EITHER THE ACTUAL DRG OR THE AVERAGE PAYMENT LEVEL ACROSS DRGS.

IN ADDITION TO THE QUESTION OF WHETHER DRGS COULD PROVIDE A REASONABLE FRAMEWORK FOR PROGRAM PAYMENT, THERE ARE SIGNIFICANT IMPLEMENTATION ISSUES SUCH AS HOW PAYMENT SHOULD BE MADE. UNDER HOSPITAL PPS, IF THE DRG PAYMENT DOES NOT COVER RESOURCE USE, THE INSTITUTION HAS TO ABSORB THE LOSS. ON AVERAGE, LOSSES ON SOME CASES SHOULD BE COVERED BY GAINS ON OTHER CASES. HOWEVER, THE HOSPITAL IS NEVER ALLOWED TO BILL THE BENEFICIARY FOR THE CASES WHERE LOSSES OCCUR SINCE THIS WOULD CLEARLY DILUTE THE INCENTIVES FOR EFFICIENCY.

CURRENTLY, NON-PARTICIPATING PHYSICIANS HAVE THE OPTION TO ACCEPT ASSIGNMENT ON ALL, SOME OR NONE OF THEIR CASES. IF THIS CURRENT ASSIGNMENT POLICY IS MAINTAINED UNDER A PHYSICIAN DRG SYSTEM, PHYSICIANS WOULD BE ABLE TO BILL THE BENEFICIARY WHEN THE CASE PAYMENT DOES NOT COVER COSTS. THIS WOULD TEND TO DILUTE THE INCENTIVES FOR EFFICIENCY COMPARED TO THOSE CONTAINED IN THE HOSPITAL PPS SYSTEM. IT WOULD ALSO SUBJECT THE SICKEST BENEFICIARIES TO CATASTROPHIC EXTRA-BILLING LIABILITY.

ANOTHER PAYMENT ISSUE IS THE QUESTION OF WHOM TO PAY. THE

PHYSICIAN DRG PAYMENT COULD BE FOLDED INTO THE HOSPITAL PPS PAYMENT, OR PAID AS A SEPARATE ADD-ON, WITH THE HOSPITAL DETERMINING HOW PAYMENT SHOULD BE MADE TO THE INVOLVED PHYSICIANS. THIS APPROACH WOULD PLACE AN ADDITIONAL ADMINISTRATIVE BURDEN ON HOSPITALS AND WOULD UNDOUBTEDLY RESULT IN STRAINED HOSPITAL-PHYSICIAN RELATIONS.

PAYMENT COULD BE MADE TO THE ATTENDING PHYSICIAN, WHO WOULD BE RESPONSIBLE FOR OBTAINING SERVICES FROM OTHER PHYSICIANS AS REQUIRED AND FOR BEARING THE FINANCIAL RISK FOR THE COST OF THE CASE. THIS ARRANGEMENT WOULD SEEM TO MAXIMIZE THE INCENTIVES FOR CONTROLLING COSTS AND ENCOURAGING EFFICIENCY. HOWEVER, IN ORDER FOR A DRG SYSTEM TO WORK FAIRLY, AN INDIVIDUAL PHYSICIAN MUST TREAT A LARGE VOLUME OF CASES WITHIN THE SAME DRG. IT IS ONLY IN THIS WAY THAT THE PAYMENTS WOULD, ON AVERAGE, COVER RESOURCE USE. SINCE MOST PHYSICIANS WOULD NOT TREAT ENOUGH PATIENTS WITHIN THE SAME DRG, A DRG-BASED PAYMENT SYSTEM COULD SUBJECT THE ATTENDING PHYSICIAN TO MORE RISK THAN HE OR SHE COULD BEAR.

THIS LEAVES PAYMENT TO THE HOSPITAL MEDICAL STAFF. HOWEVER, SUCH STAFFS CURRENTLY ARE NOT ORGANIZED TO ACCEPT AND DISTRIBUTE PAYMENT AND IT IS UNCERTAIN WHETHER THEY COULD BE ORGANIZED TO DO SO. IN ADDITION, NO EVIDENCE EXISTS AS TO WHETHER THE INCENTIVES FOR EFFICIENCY, WHICH IS THE MAJOR

THRUST OF THIS PAYMENT SYSTEM, WOULD BE EFFECTIVE WITH THIS METHOD OF PAYMENT.

ANOTHER ISSUE THAT HAS BEEN RAISED IN REGARD TO A DRG-BASED PAYMENT SYSTEM IS THE IMPACT THAT IT COULD HAVE ON QUALITY OF CARE. UNDER PPS, HOSPITALS HAVE THE ECONOMIC INCENTIVE TO CONTROL THE PROVISION OF SERVICES IN ORDER TO FUNCTION WITHIN A FIXED PAYMENT. HOWEVER, THE ATTENDING PHYSICIAN DOES NOT HAVE THE SAME ECONOMIC INCENTIVES AND THUS SERVES AS A PATIENT ADVOCATE. HOW WOULD THIS RELATIONSHIP CHANGE IF THE INCENTIVES OF THE HOSPITAL AND PHYSICIAN WERE ALIGNED?

SINCE INPATIENT SERVICES ACCOUNT FOR ONLY 60 PERCENT OF PHYSICIAN SERVICES, A DRG-BASED PAYMENT SYSTEM WOULD NOT ADDRESS THE REST OF THE SYSTEM. AS MORE PROCEDURES ARE PERFORMED IN AN OUTPATIENT OR OFFICE SETTING, THE PERCENT OF PAYMENT COVERED BY THIS SYSTEM WOULD DECLINE.

IN SUMMARY, ALTHOUGH A DRG-BASED PAYMENT MAY SEEM SOMEWHAT TECHNICALLY FEASIBLE THERE ARE MANY SERIOUS IMPLEMENTATION ISSUES THAT NEED TO BE RESOLVED. THE SYSTEM COULD HAVE A NEGATIVE IMPACT ON QUALITY OF CARE AND WOULD NOT AFFECT 40 PERCENT OF PHYSICIAN PAYMENTS. FINALLY, ALTHOUGH THE MEDICARE HOSPTIAL PROSPECTIVE PAYMENT SYSTEM, BASED ON DRGS, IS A DRAMATIC IMPROVEMENT OVER COST REIMBURSEMENT, THE ADMINISTRATION VIEWS IT AS OVERLY REGULATORY. IT SHOULD BE

SEEN AS A TRANSITION TOWARD ULTIMATE MEDICARE REFORM THROUGH CAPITATION, AND THEREFORE SHOULD NOT BE EXTENDED TO INCLUDE THE PAYMENT OF PHYSICIANS.

FEE SCHEDULES

ONE APPROACH TO REFORM WOULD BE TO REPLACE THE CPR SYSTEM WITH A FEE SCHEDULE WHICH WOULD LIST MEDICARE'S MAXIMUM ALLOWANCE FOR EACH PROCEDURE. THIS FEE SCHEDULE COULD BE BASED ON CURRENT CHARGES OR ON A RELATIVE VALUE SCALE (RVS) WHICH WOULD HAVE A "WEIGHT" FOR EACH PROCEDURE BASED ON THE ASSOCIATED RELATIVE RESOURCE COSTS. REGARDLESS OF THE METHODOLOGY, THE MAXIMUM ALLOWANCE WOULD BE THE SAME FOR ALL PHYSICIANS WHO PROVIDE A SERVICE IN AN AREA.

SINCE IMPLEMENTATION OF A FEE SCHEDULE WOULD ELIMINATE THE CUSTOMARY AND PREVAILING CHARGES SCREENS, ONE COULD ARGUE THAT THE SYSTEM WOULD BE EASIER TO UNDERSTAND THAN CPR. HOWEVER, OTHER PROBLEMS THAT CURRENTLY ARE A SOURCE OF CONFUSION WOULD REMAIN.

- O PHYSICIANS WOULD STILL HAVE 7,500 CODES UNDER WHICH TO BILL, WITH THE DIFFERENCE BETWEEN THE SERVICE INPUTS PROVIDED IN, FOR EXAMPLE, THE 6 DIFFERENT LEVELS OF MEDICAL OFFICE VISITS NOT CLEARLY DEFINED.

- O ALTHOUGH BENEFICIARIES WOULD HAVE AN EASIER TIME

> DETERMINING THE MEDICARE ALLOWANCE UNDER A FEE SCHEDULE THAN UNDER CPR, WITH THE EXCEPTION OF PARTICIPATING PHYSICIANS, THEY WOULD STILL NOT KNOW THEIR POTENTIAL EXTRA-BILLING LIABILITY IN ADVANCE SINCE THEY WOULD NOT KNOW THE PHYSICIAN'S ACTUAL CHARGE. THUS, A FEE SCHEDULE WOULD ONLY MARGINALLY IMPROVE BENEFICIARIES' ABILITY TO SHOP AROUND FOR THE BEST PRICE.

ALTHOUGH, PRIOR TO THE ENACTMENT OF THE ECONOMIC INDEX, PHYSICIANS' ACTUAL BILLINGS DETERMINED FUTURE CUSTOMARY AND PREVAILING CHARGES UNDER CPR, THE ECONOMIC INDEX NOW ACTS TO LIMIT THE INCREASE IN PREVAILING CHARGES. THUS, CPR IS INCREASINGLY RESEMBLING A SERIES OF SPECIALTY SPECIFIC LOCAL FEE SCHEDULES SET AT THE ECONOMIC INDEX-CONSTRAINED PREVAILING CHARGE LEVEL. ANY UPDATE FACTOR FOR A FEE SCHEDULE WOULD PROBABLY RESEMBLE THE CURRENT ECONOMIC INDEX. THUS, FEE SCHEDULES WOULD PROVIDE LIMITED ADDITIONAL CONTROL OVER THE PRICE COMPONENT OF PROGRAM INCREASES.

NEITHER WOULD FEE SCHEDULES PROVIDE ANY ADDITIONAL INCENTIVES FOR CONTROL OVER UTILIZATION/INTENSITY. WITH 7,500 CODES TO BILL UNDER, THERE IS AN OPPORTUNITY TO UPCODE SERVICES, UNBUNDLE SERVICES OR FURNISH SERVICES NOT PREVIOUSLY PROVIDED. TO THE EXTENT THAT A FEE SCHEDULE WOULD HAVE REDISTRIBUTIVE EFFECTS AMONG SPECIALISTS OR REGIONS OF THE

COUNTRY, PRODUCING "WINNERS" AND "LOSERS" AMONG PHYSICIANS. THE INCENTIVES WOULD BE STRONGER THAN UNDER THE CURRENT SYSTEM TO GENERATE INCREASED UTILIZATION/INTENSITY IN ORDER TO MAINTAIN INCOME.

THESE INCENTIVES TO INCREASE UTILIZATION/INTENSITY WOULD MAKE IT MORE DIFFICULT TO DEVELOP A SYSTEM WHICH WOULD BE BUDGET NEUTRAL SINCE ESTIMATES OF THE POTENTIAL INCREASE IN UTILIZATION/INTENSITY WOULD HAVE TO BE MADE IN ORDER TO PROVIDE FOR AN OFFSET IN THE FEE LEVELS. IT MAY BE NECESSARY TO INCORPORATE FEATURES UTILIZED IN CANADA AND WEST GERMANY, WHEREBY, IF UTILIZATION/INTENSITY INCREASES BY MORE THAN THE PROJECTED AMOUNT, THE FEE SCHEDULE INCREASE IN THE FOLLOWING YEAR IS REDUCED TO OFFSET THE HIGHER THAN PROJECTED UTILIZATION. THESE REDUCTIONS WOULD AFFECT ALL PHYSICIANS. THUS THEY WOULD PENALIZE NOT ONLY THE OVERUTILIZERS BUT ALSO THE PHYSICIANS WHO HAVE BEEN ATTEMPTING TO RESTRAIN COSTS.

SOME ARGUE THAT A FEE SCHEDULE INCORPORATING A RELATIVE VALUE SCALE BASED ON RESOURCE INPUTS WOULD ELIMINATE THE PERCEIVED PAYMENT BIASES IN CPR. ALTHOUGH MANY SECTORS IN THE HEALTH CARE COMMUNITY BELIEVE THAT SUCH A RELATIVE VALUE SCALE WOULD WORK, THERE IS NO CONSENSUS ON HOW IT SHOULD BE DEVELOPED. SUCH AN EFFORT WOULD BE TIME CONSUMING AND NOT AS OBJECTIVE AS IS SOMETIMES PERCEIVED.

IN SIMPLIFIED TERMS, A RESOURCE-BASED RVS AMOUNTS TO A COMPARABLE WORTH APPROACH, RELATING THE VALUE OF THE SERVICES PROVIDED BY ONE SPECIALTY TO THE SERVICES PROVIDED BY OTHER SPECIALTIES. RATHER THAN BASING PRICES ON MARKET MECHANISMS, IT RELIES ON A CONSENSUS OF "EXPERTS" TO DETERMINE WHAT RELATIVE PRICES SHOULD BE. IF THE RVS WERE USED IN THE CONSTRUCTION OF A FEE SCHEDULE, IT COULD RESULT IN THE PRICE OF SOME PROCEDURES BEING SET SIGNIFICANTLY HIGHER THAN PHYSICIANS NORMALLY CHARGE, WHILE OTHER PROCEDURES COULD BE REDUCED BELOW MARKET CHARGES. ALL THESE ADJUSTMENTS WOULD PRODUCE SIGNIFICANT REDISTRIBUTIONS OF BENEFIT PAYMENTS AMONG SPECIALISTS AND BETWEEN GEOGRAPHIC AREAS. THIS COULD HAVE A NEGATIVE IMPACT ON PHYSICIAN WILLINGNESS TO PROVIDE SERVICES AS WELL AS ON BENEFICIARY OUT-OF-POCKET EXPENDITURES.

IN SUMMARY, WHILE FEE SCHEDULES MIGHT BE SOMEWHAT LESS CONFUSING THAN CPR, THEY WOULD NOT IMPROVE OUR ABILITY TO CONTROL EITHER THE PRICE OR UTILIZATION/INTENSITY OF SERVICES. ALTHOUGH FEE SCHEDULES BASED ON RELATIVE VALUE SCALES COULD BE DESIGNED TO CORRECT PERCEIVED BIASES IN CPR, THE APPROACH IS NOT MARKET BASED AND COULD POTENTIALLY HAVE MAJOR REDISTRIBUTIVE EFFECTS THAT WOULD HAVE A NEGATIVE IMPACT ON ACCESS AND BENEFICIARY FINANCIAL PROTECTION. FINALLY, FEE SCHEDULES ARE INHERENTLY REGULATORY IN NATURE, AND THEREFORE ARE COUNTER TO ADMINISTRATION POLICY. WE BELIEVE THAT ULTIMATE MEDICARE REFORM MUST BE CENTERED ON COMPETITION AND CHOICE

THROUGH CAPITATION.

CAPITATION

THE ONLY APPROACH WHICH ADDRESSES BOTH PRICE AND UTILIZATION/INTENSITY OF SERVICES IS CAPITATION. UNDER SUCH SYSTEMS, A SINGLE PAYMENT IS MADE TO AN ENTITY FOR THE PROVISION OF ALL NECESSARY HEALTH CARE SERVICES IN A YEAR, INCLUDING BUT NOT LIMITED TO PHYSICIAN SERVICES.

WE CURRENTLY HAVE CAPITATED SYSTEMS IN HMOS AND CMPS. WE ARE PROPOSING LEGISLATION TO EXPAND ON THE OPTIONS AVAILABLE TO OUR BENEFICIARIES THROUGH THE USE OF VOUCHERS. WE ARE ALSO EXPLORING, THROUGH DEMONSTRATIONS, A VARIETY OF NEW APPROACHES TO CAPITATION.

ALTHOUGH PAYMENT TO HMOS FOR THE FULL MEDICARE BENEFIT PACKAGE HAS BEEN AUTHORIZED SINCE 1972, ONLY RECENTLY IN THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) WERE RISK SHARING CONTRACTS AT 95 PERCENT OF THE ADJUSTED AVERAGE PER CAPITA COSTS (AAPCC) MADE AVAILABLE. WE BELIEVE THAT THIS AND OTHER CHANGES IN HMO REIMBURSEMENT MANDATED BY TEFRA WILL RESULT IN INCREASED BENEFICIARY ENROLLMENT IN CAPITATED SYSTEMS. AS OF LAST MONTH, 78 RISK CONTRACTS WERE SIGNED IN 25 STATES WITH AN ADDITIONAL 84 CONTRACTS PENDING. IF THESE ADDITIONAL CONTRACTS ARE SIGNED, THERE WILL BE TEFRA HMO/CMPS OPERATING IN 30 STATES. OVER 400,000 BENEFICIARIES ARE

ENROLLED UNDER THESE RISK CONTRACTS WITH A PROJECTED 1.4 MILLION BY THE END OF FY 87.

UNDER OUR VOUCHER PROPOSAL WE WILL BUILD ON THE REFORMS TO HMO/CMP FINANCING IN TEFRA. OUR PROPOSAL WOULD:

-- EXPAND THE POOL OF ENTITIES THAT COULD QUALIFY FOR CAPITATED PAYMENTS BY ALLOWING INDEMNITY INSURERS AS WELL AS HMO'S AND CMP'S TO PROVIDE ALTERNATIVE COVERAGE;

-- MAKE ENROLLMENT IN PRIVATE PLANS MORE ATTRACTIVE TO BENEFICIARIES BY ALLOWING EMPLOYERS TO COMBINE THE MEDICARE PAYMENT WITH THEIR OWN PREMIUMS FOR ANNUITANTS TO SECURE A UNIFORM PLAN WITHOUT DUPLICATIVE COVERAGE, AND

-- ELIMINATE CERTAIN CURRENT REQUIREMENTS THAT ARE OVERLY REGULATORY; SUCH AS THE REQUIREMENT THAT HMOS AND CMPS OFFER THE ACTUAL MEDICARE BENEFIT PACKAGE. SUBJECT TO A TEST OF ACTUARIAL EQUIVALENCE OF BENEFITS, PLANS WOULD BE FREE TO RESTRUCTURE THE MEDICARE BENEFIT PACKAGE.

WE ARE CONSIDERING, AMONG OTHER POSSIBLE ALTERNATIVES, THE DEMONSTRATION OF A GEOGRAPHIC CAPITATION APPROACH. IN

CONTRAST TO AN HMO OR CMP THAT SERVES ONLY THOSE INDIVIDUALS WHO ENROLL IN IT, UNDER GEOGRAPHIC CAPITATION AN ENTITY WOULD BE RESPONSIBLE FOR ENSURING THE PROVISION OF BENEFITS TO ALL BENEFICIARIES IN A GEOGRAPHIC AREA. THE ENTITY WOULD OFFER A NUMBER OF OPTIONS TO BENEFICIARIES INCLUDING TRADITIONAL MEDICARE AS WELL AS OPTIONS INCORPORATING COMPONENTS OF PREFERRED PROVIDER ORGANIZATIONS.

SHORT TERM SYSTEM REFINEMENTS

CLEARLY, NOT ALL OF OUR BENEFICIARIES WILL BE SERVED BY CAPITATED SYSTEMS IMMEDIATELY. THEREFORE, WE ARE EXAMINING STEPS THAT COULD BE TAKEN IN THE NEAR TERM TO REFINE CPR AND TO MAINTAIN CONSTRAINT ON SPENDING FOR PHYSICIANS' SERVICES. I WOULD LIKE TO BRIEFLY DISCUSS TWO OF THESE POSSIBLE INITIATIVES: ADJUSTING OVERPRICED PROCEDURES AND EXAMINING CURRENT DIFFERENTIALS FOR LOCALITY AND SPECIALTY.

IN OUR INITIATIVE ON OVERPRICED PROCEDURES, WE WILL BE EXAMINING PROCEDURES WHERE THERE HAVE BEEN SIGNIFICANT IMPROVEMENTS IN MEDICAL TECHNOLOGY OR SURGICAL TECHNIQUES THAT HAVE RESULTED IN LOWER PRODUCTION COSTS IN ORDER TO DETERMINE WHETHER A REDUCTION IN CURRENT PROGRAM PAYMENT IS WARRANTED. PACEMAKER INSERTION IS AN EXAMPLE OF THE TYPE OF PROCEDURE WHICH WOULD FIT INTO THIS CATEGORY.

IN THE PROCESS OF PREPARING THE REPORT TO CONGRESS ON

PACEMAKERS. WE HAVE DETERMINED THAT THE AMOUNT OF TIME REQUIRED TO PERFORM A PACEMAKER INSERTION HAS DECREASED SUBSTANTIALLY SINCE THE PROCEDURE WAS INTRODUCED. IF THE MARKET WERE WORKING PROPERLY, WE WOULD HAVE SEEN A DROP IN CHARGES FOR THIS PROCEDURE. INSTEAD, HOWEVER, REIMBURSEMENT FOR THE PROCEDURE HAS INCREASED STEADILY. NEITHER THE FEDERAL GOVERNMENT NOR THE MEDICARE BENEFICIARIES HAVE BENEFITTED FINANCIALLY FROM THE DECLINE IN PRODUCTION COSTS, AS WOULD HAVE BEEN THE CASE IN MORE COMPETITIVE SECTORS OF THE ECONOMY. CLEARLY, THERE APPEARS TO BE A STRONG JUSTIFICATION HERE FOR A DOWNWARD ADJUSTMENT OF CURRENT PAYMENT LEVELS.

ANOTHER REFINEMENT UNDER CONSIDERATION IS TO EXAMINE WHETHER CURRENT LOCALITY AND SPECIALTY DESIGNATIONS WITHIN CARRIERS ARE JUSTIFIED. A LOCALITY IS A GEOGRAPHIC AREA USED BY A CARRIER TO DERIVE PREVAILING CHARGES FOR SERVICES. SOME CARRIERS HAVE STATE-WIDE LOCALITIES, OTHERS REGIONAL LOCALITIES, STILL OTHERS HAVE SEPARATE LOCALITIES FOR URBAN AND RURAL AREAS. WHILE INTER-CARRIER VARIATION IN PREVAILING CHARGE LEVELS MAY JUSTIFY MULTIPLE LOCALITIES IN ONE CARRIER, IT SEEMS QUESTIONABLE THAT ONE CAN JUSTIFY 32 LOCALITIES IN ONE CARRIER, AS EXISTS IN TEXAS.

JUST AS PRACTICE IN REGARD TO LOCALITY VARIES BY CARRIER, SO TOO DOES PRACTICE IN REGARD TO SPECIALTY RECOGNITION. CARRIERS CURRENTLY HAVE WIDE LATITUDE IN DECIDING HOW TO SET

UP SPECIALTY PREVAILING CHARGE SCREENS AND IN DETERMINING WHETHER A PHYSICIAN IS A SPECIALIST. WE ARE EXAMINING THIS AREA TO DETERMINE WHERE SPECIALTY DIFFERENTIALS ARE APPROPRIATE.

IN SUMMARY, WE HOPE TO ADDRESS SOME OF THE LONGSTANDING CRITICISMS THAT HAVE BEEN MADE ABOUT CPR AND TO MAINTAIN CONSTRAINT ON SPENDING FOR PHYSICIANS' SERVICES. WHILE WORKING ON THESE SHORT-TERM SYSTEM REFINEMENTS, WE WILL FOCUS OUR ATTENTION ON OUR INITIATIVES TO IMPLEMENT MEDICARE REFORM THROUGH CAPITATION. IT IS ONLY THROUGH CAPITATION THAT WE CAN STRENGTHEN THE COMPETITIVE FORCES IN OUR HEALTH CARE SYSTEM. COMPETITION AND CONSUMER CHOICE, RATHER THAN MORE ELABORATE REGULATORY OPTIONS, ARE THE BEST WAYS TO ACHIEVE THE PROVISION OF QUALITY CARE SERVICES WHILE RESTRAINING THE GROWTH OF SPENDING FOR HEALTH CARE.

I THANK YOU FOR THE OPPORTUNITY TO DISCUSS THESE ISSUES WITH YOU. I'D BE HAPPY TO RESPOND TO ANY QUESTIONS THAT YOU MAY HAVE.

Senator DURENBERGER. Thank you very much for the presentation and the larger effort behind it.

Let me just say for the record that I think the process that we have been involved in for the last 2½ years, from the time that we passed the Social Security amendments and suggested an analysis of prospectively pricing all provider products, has been an excellent one. And let me just compliment everybody at HCFA, all the contractors, all of the professional association groups, and the beneficiary groups. A lot of people are in this room today not because they are here to be against something, but they are here to be for something. It is just a real good feeling to sit up here and know that there is a lot of disagreement in this room about exactly how to do something, but that everybody seems to be working toward a more rational process.

As I look through this big thick book here of all this testimony, I see varying views on how to do this—you have encapsulated them into three areas, Henry—but I think we have come so far in a couple or 3 years in our attitudes toward these things that it is a real pleasure to be able to sit up here and not ask you pushy, nitpicky kinds of questions.

I will ask you one like that, which is on the issue of tbe physician freeze in part B. I started down that track a little bit in terms of statistics to find out what you do know about it, because it is my feeling that if reconciliation isn't going anywhere, we need to do something about that October 1 date. Can you give us any advice on the consequences, for example, of doing nothing? What happens to accessibility? What happens to physician participation? What could we look forward to in the next year or so if we do nothing, if we just leave that freeze in place for another year and don't make changes to participating physicians?

Dr. DESMARAIS. Well, certainly you would have to do something; because, if you do nothing, then the freeze comes off at the appropriate time, and we would go and provide for an increase.

But one thing we have observed, and it has been somewhat surprising to us, is that, despite the freeze that we have had now for over 17 months, the assignment rates for part B services have risen pretty dramatically, and now nearly 70 percent of services being provided under part B to Medicare beneficiaries are provided under assignment. That is much higher than the historic trend. In prior years, there had been small increases, but in fiscal year 1986 it rose dramatically even in the face of a freeze.

Now, certainly, as I have observed earlier, there is a lot going on, and it makes some of our estimating and guesstimating a little difficult.

We also know that in the first year of this freeze 30 percent of physicians—and I define that broadly to include the limited-license practitioners—were participating physicians. We are able to tell you today that for fiscal year 1986, 28 percent of physicians are participating physicians. Some of these physicians are new entrants to the participating program; some dropped out. But still, instead of 30 percent the first year of the freeze, we have 28 percent at the moment.

Senator DURENBERGER. My problem at the moment—and you don't know where to go to prove anything—is that you are not going to convince me with statistics, because I know that behind all of those physicians are rising costs. I sit out there and I just listen from State to State to what is happening on malpractice premiums. I know what those people are facing. So, you can't do it to me on statistics.

Now, if I say, "How many obstetricians?" or how many of this or how many of that—obstetricians aren't appropriate, I guess, for the elderly—or how about small towns? I mean, take me way out in rural Minnesota some place. Yes, you can get something out of just plain economic pressure, but that doesn't mean that we still have an equal access across this country to adequate physician services, and I think that is what is bothering me. You don't have the data that proves that this is uniform all across the country, do you?

Dr. DESMARAIS. No, we don't.

The other observation that is surprising—and this is not reported or collected by us—Medical Economics published a report that said that physician incomes in 1984 rose on the average a 7.8 percent, to a median of $101,970. It is interesting, given all the things going on, to have the median income rise.

Now, I am not vouching for the validity of that particular survey; but it is a pretty respected organization, they perform this survey every year. An interesting fact.

Senator DURENBERGER. Yes. And it makes great material when you get into a debate on whether Medicare ought to have the hell shot out of it in a Gramm-Rudman. I mean, they can quote that stuff up and say, "Look, all we are doing, and physicians are still getting richer. The hospitals are still getting richer. Let's cut some more."

So, all I am going to say is that I am bothered by the macro statistics.

Let me ask you what "geographic capitation is," as the Department considers demonstrations?

Dr. DESMARAIS. OK. Geographic capitation would simply take an area—a county, a State, even a smaller area—and select an entity at risk like an insuror and say to that entity, "In return for receiving a capitated payment, you will be responsible for paying for the health care services provided to each beneficiary in this area." Now, the beneficiaries in the area will have choices. One choice they will certainly have will be traditional Medicare. They may be offered additional choices, some may involve wraparound of cost-sharing and deductibles, copayments, additional benefits, and so on, but the entity would be at risk.

So, in that situation we clearly don't have any selecting of patients; everybody in that geographic area would be served and covered by that entity.

Senator DURENBERGER. I should have told you I was going to ask this kind of question, but I didn't think of it until just now.

Take the area where my folks spend 9 months out of the year, in Clearwater, FL. Now, I spent Thanksgiving with my mother, and she is debating getting out of her $78-a-month ripoff Minnesota Medicare something-or-other Medigap plan and into what the next door neighbor has. The next door neighbor has Gold Plus. I take it

that is some kind of a demonstration by HCFA, because it says that on there. Is that right?

Dr. DESMARAIS. I think it was a demonstration; I believe it is now a regular part of the HMO Program.

Senator DURENBERGER. Well, the literature down there that I read and the phone calls that she made to somebody in Miami, who happens to be from Minnesota, says—and this is just what it says—"It's free. It doesn't cost you anything to be in this plan; everything is covered, with a few very, very small exemptions. But there is no premium."

Now, she has nothing to compare that with. I said, "That sounds too good to be true." I asked some of the local doctors if they would be in it. They said, "Well, obviously what is going on here is that they are sending her to certain physicians in certain places, so she is going to lose her freedom of choice." Well, she doesn't mind losing her freedom of choice as long as she knows she is getting quality health care. But she doesn't have another plan similar to that to compare it to.

Now, I guess the question I am asking you is not to give me the details of what Gold Plus is doing for my mother or whatever; but if you are going to do one demonstration in an area, are you going to do a demonstration in another area? Can you do it with only one entity?

Dr. DESMARAIS. No. Although the entity would cover the bulk of the people in the area, we would certainly want to have traditional HMO's, competitive medical plans, also in that area as alternatives available.

Senator DURENBERGER. You wouldn't put your demonstration into Clearwater/St. Pete, that area, if there wasn't already in existence similar plans that priced their products in similar ways, like "It's a prepaid plan, no premiums, we work off of benefits and cost sharing" and that sort of thing?

Dr. DESMARAIS. I would state it in a little different way. If there were an HMO there, that would be great, and it would be allowed to continue. If there weren't one there, we would allow one to come in. But it is a question of allowing other alternative capitated arrangements, even in that environment.

Senator DURENBERGER. Because you know enough about how the elderly buy health care. Now, maybe Vita can tell us differently, but it seems like No. 1 is, If you can get rid of all of this horrible paperwork, and "reasonable and customary charges" and ripoffs, and all that sort of thing, I want it. You know, I'll buy into it. But you know enough about how they buy so that you wouldn't permit them to be subjected to a noncompetitive demonstration, would you? In your notion?

Dr. DESMARAIS. Well, that is exactly what we are trying to avoid. We want a competitive environment, so we are certainly not going to start a demonstration that will take us in the opposite direction.

But I will say that in the discussions of geographic capitation, the issue of the competitiveness of that approach has been one of the things at the forefront of the debate, about whether or not we should do this, and if we do it, how do we do it, and where do we do it?

We have had some discussions with interested parties. Some of our own Medicare contractors in a variety of States have expressed some interest. We are also getting interest, I might add, from large employers who say, "Gee, I might want to keep my annuitants in a kind of an employer-at-risk program." That is a different kind of a capitation, and you might want to call it geographic; it's by employeees, if you will. But it is another alternative capitated approach.

Senator DURENBERGER. But we do understand that, just because there is 97 HMO's in the Boston area, that does not mean we have got competition. Or just because there is a PPO in town, it does not mean there is marketplace competition. You understand that.

Dr. DESMARAIS. Well, it certainly helps to have those alternatives available. It is certainly far better than not having an HMO in your community.

Senator DURENBERGER. Not if they can't get to the market. I mean, if they have got 10,000 members in a community of 2 million people, that is not competition. I mean, they can't get into the Boston Globe; they can't get into the Minneapolis Tribune; they can't get to the market. They have got to be big enough so that they can compete with your demonstration or Tresnowski's Blue Cross and Blue Shield market leverage. You understand that, don't you?

Dr. DESMARAIS. Well, what I am trying to say is that we are trying to avoid anything that would smack of anticompetitiveness as we move along, whether it is a new demonstration or a new program policy. We are trying to avoid anything like that.

Senator DURENBERGER. All right.

Max.

Senator BAUCUS. I am curious, as you are so strongly committed to the capitation approach here, whether the Department, HCFA included, is continuing to look aggressively at the other options, too—that is, the relative value of the DRG approaches.

Dr. DESMARAIS. We have done an awful lot of work on the DRG's. We have also done work both in-house and with contractors on relative values.

Senator BAUCUS. The question is, are you looking at those with the same intensity? Or are you backing off on those other options?

Dr. DESMARAIS. I think we are looking at them with somewhat less intensity now, based on what we know. But we haven't stopped work completely on all of the others.

Senator BAUCUS. Considering that less than 2 percent of Medicare's current beneficiaries are now enrolled in a capitated plan such as an HMO, what percentage of the total beneficiary population do you seriously believe could be ultimately covered?

Dr. DESMARAIS. Well, we hope that by 1990 we will have about 25 percent of our beneficiaries in those kinds of environments.

I might add that certain private-sector analysts are talking about maybe 30 percent of the entire population in HMO's and 40 percent in PPO's by 1990. Now, whether that is exaggerated or not, I don't know; but the degree of change that has occurred over the last 5 years is certainly enormous, and I would even hate to predict what we will face in the next 5 years.

Senator BAUCUS. What do you base that on? I ask because, for example, in States like Montana there is not a single HMO or PPO. And I talked to various HMO officials who say, "no way is there going to be an HMO in Montana." So, what about these more rural areas where there aren't any HMO's? How are you going to cover beneficiaries in those areas?

Dr. DESMARAIS. That is why we don't expect capitation to occur overnight. But I will say that since April 1 we have signed 78 contracts, we have 84 pending, and when those are approved we will have HMO's in 36 States. I think we are making dramatic strides.

You are right. And we say very clearly in my statement that—

Senator BAUCUS. But I am trying to understand why you think there is going to be an HMO in some of these rural areas.

Dr. DESMARAIS. Well, there may not be an HMO. There may be, but other alternatives might be available like a geographic capitated approach, which would cover the whole area.

Senator BAUCUS. Well, would you explain that? I am not quite sure how that works, either. You know, there are some pretty sparsely populated counties in some parts of our country, particularly in the West.

Dr. DESMARAIS. There is an insurance company that would serve that area, and we would make a capitated payment to cover every Medicare beneficiary. And for the beneficiary, not much might change in some respects.

Senator BAUCUS. How many insurance companies are willing to go along with this?

Dr. DESMARAIS. Many, many have expressed tremendous interest, and I think that will increase.

Senator BAUCUS. What will happen to the beneficiary who happens to reside in a certain rural county that is not covered by a particular insurance company that, say, HCFA has desigated as the insuror under some capitation program? How is that beneficiary going to be taken care of?

Dr. DESMARAIS. I am sorry, I am not sure I understood your question.

Senator BAUCUS. Well, what happens when a certain beneficiary is not insured by the company selected by HCFA?

Ms. KELLY. Senator Baucus, in a geographic capitation scheme all the beneficiaries in a defined geographic area would be capitated to the insuror who would go at risk. So, in that particular geographic area, everyone would be part of this demonstration.

Dr. DESMARAIS. We would be the insuror, essentially. We are paying the insuror.

Senator BAUCUS. And are you convinced that all insurance companies are willing to go along with this?

Dr. DESMARAIS. No, I am not saying that. I am saying, clearly we want to make sure that every beneficiary has an available alternative, and we are moving toward capitation. We know that we won't get there overnight. We are not jettisoning what we have today, which is the customary, prevailing and reasonable charge system. We will try to refine that in the meantime, and then we will see where we are in the next 5 years.

But certainly, the more people covered by capitation, the less important this reasonable-charge alternative is or the fee for services.

Senator BAUCUS. What happens if an HMO goes broke? If HCFA makes a certain payment to an HMO and the HMO goes belly up? What is going to happen to the beneficiaries?

Dr. DESMARAIS. First we have in place a mechanism to try to prevent that. Before they sign a contract with us they have to run through the gamut of a number of tests and an analysis by the Public Health Service, and among the things we look for is to prevent insolvency—that they are adequately capitalized, that they may have some reinsurance, and so on. That is taken care of.

Senator BAUCUS. Are you suggesting there will be a 100-percent guarantee to the beneficiary, or an 80-percent guarantee?

Ms. KELLY. Well, Senator, if the HMO or the CMP for some reason would happen to become financially unsound, the beneficiary would revert to the regular fee-for-service system. They would revert if any particular HMO or CMP would unfortunately go out of business. The beneficiaries enrolled in that organization would go back to the regular fee-for-service system; so, they would still have insurance coverage.

Senator BAUCUS. And are you also fairly certain that, when all this is said and done, if we go this route, there will be less paperwork and fewer regulations?

Dr. DESMARAIS. That is certainly our goal, and certainly there wouldn't be a need to do claims processing if you are making capitated payments. So, there should be some tremendous administrative improvements and a lot more flexibility in the system.

I want to emphasize to you: While we say we want capitation, we are not sitting here saying we have all the answers; we have a lot of work in place to get some of those answers, to get better at paying capitated systems, to try new approaches to making capitated payments. We just see it as a way of dealing with not only price but volume, and a way of getting more competition into the system.

Senator BAUCUS. Fine. I appreciate that. And obviously from the questions I am asking I am encouraging you to pay a lot of attention to the rural problem, because it is very serious. You can't get doctors in the rural areas—that hurts. And if we go this route, before we go this route, we are going to have to come up with good answers and good ways to make sure that seniors in rural areas are adequately covered.

Dr. DESMARAIS. As I said earlier in my statement, part of the exolanation for that may be the old system we have in place today, which pays doctors in urban areas more per service than it does for rural doctors. Work done by many people suggests that if you look at the practice cost, the cost o racticing medicine, in those two settings, there is not that great a disparity, that while there may be greater expenses for some items in an urban setting, there are other offsetting kinds of things that rural doctors must face in setting up their own practices. So, these geographic disparities may in part explain the fact that we haven't been able to get as many people into the rural areas.

Senator BAUCUS. Thank you.

Senator DURENBERGER. Thank you all very much, and Henry.

Dr. DESMARAIS. Thank you, Mr. Chairman.

Senator DURENBERGER. Carol and Allen, thank you.

Our next witness is Vita Ostrander, the leader of the American Association of Retired Persons.

Vita, welcome back to our set of hearings. I will obviously include the American Association of Retired Persons in my compliments to the organizations that have contributed so much to moving the policy issue on reimbursement, prospective reimbursement. I think not only is your statement, which will be made part of the record, an excellent statement, but the work that AARP has done on examining the various issues involved in physician reimbursement—the consulting research that you have contracted, and so forth—is certainly a major contribution to the effort as well.

So, we welcome you today, and you may abbreviate your statement or deliver it, as you wish.

STATEMENT OF VITA R. OSTRANDER, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Ms. OSTRANDER. Thank you, Senator Durenberger.

I appreciate being given this opportunity to discuss AARP's views on reforming Medicare's method of paying physicians. As I am sure each of you realizes, continuing escalation in the cost of seeing a doctor is not only straining the Government's ability and willingness to pay, it is limiting access to care for many older persons who simply cannot keep up the pace.

I commend you for recognizing the urgency with which we must address questions of health care access and affordability. But I would also caution lawmakers against rushing too quickly into a system that may look good at first but have unforeseen pitfalls such as we are experiencing with Medicare's new payment system for hospitals.

While the Nation's largest membership organization of older Americans does believe changes in the fee-for-service system must be made, we hope changes will be made gradually and that no one method will be substituted for the current system.

I know my time is limited, Mr. Chairman, but I would like to discuss why AARP feels new payment methods must be stopped. Perhaps the most important reason stems from the new PPS system for hospitals. PPS and its diagnosis-related group system has certainly saved money for the hospital insurance trust fund, but costs for beneficiaries have increased. Early discharge incentives inherent in PPS have left patients sicker at discharge, often needing expensive nursing care in their homes. Such expenses, of course, are paid under Medicare's part B, which has the 20-percent copayment feature.

Cost containment measures have also encouraged the performance of more services on an outpatient basis. Again, outpatient vists are paid under part B and therefore increase the burden on the patient. And this burden is not a light one. It would not be an exaggeration to say Medicare's coverage for physician services is inadequate. In fact, patients are now responsible for over 60 percent of the total charges due under part B.

And while we are thrilled to see an increase in the rate at which doctors are accepting assignment, we are not too pleased that over

the past few years patient liability for unassigned claims has risen by over 200 percent.

Runaway inflation in physician services at nearly twice the rate of other goods and services has made Medicare's supplemental insurance, part B, the fastest growing Federal domestic program with expenditures growing at 11.5 percent last year. This is three times the rate of general inflation. And who is the biggest beneficiary of one of America's most expensive domestic programs? Not the poor and the elderly or sick—although benefits to them are undeniable, but doctors, whose average annual incomes are over $100,000.

The current system of reimbursement, not overutilization by the elderly, is largely to blame for this situation, contrary to what some would have you believe. As was true with hospitals, Medicare's practice of reimbursing doctors for whatever services they perform only encourages them to perform more and more. Making the situation worse is the system's bias toward use of technological toys while slightiog doctors who take the time to talk to their patients.

Any restructuring of the physician payments, AARP feels, should correct inequities such as this, along with other anomalies such as differentials in payment by specialty, setting for the service, and geographic location of the physician.

It is the kind of problems I have outlined here that account for most of the increases in the cost of this program. I want to state this clearly so everyone will hear it: Beneficiary overuse cannot be linked to increasing part B costs. No study has ever demonstrated excessive or inappropriate use of reimbursed physician services by the elderly. Moreover, the elderly's per-capita visits to the doctor have remained stable at 6.5 visits per year since 1970.

It is for this reason that we reject the notion that increasing beneficiary copayments will keep older Americans from abusing physician services. It is not the beneficiary who is responsible for unconscionable increases in costs, and it should not be the beneficiary who suffers from attempts to bring down those costs. Let us learn from our mistakes with PPS for hospitals.

To that end, we have commissioned a study which we will be leaving with you today. It has not been approved by our National Legislative Council, which will meet in January. At that point we will make decisions.

I know I have already spoken too long, but before I stop I would like to add that AARP strongly urges Congress to keep its promise to physicians who participated in cost-cutting measures during the Deficit Reduction Act of 1984. The Conference Committee on Budget Reconciliation will approve that updated schedule retroactive to October 1, 1985.

Thank you.

[Ms. Ostrander's written testimony follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

MEDICARE PROSPECTIVE PAYMENT REFORM

SENATE COMMITTEE ON FINANCE

December 6, 1985

Presented by:

Vita Ostrander
President

Thank you, Mr. Chairman, for this opportunity to present the views of the American Association of Retired Persons (AARP) on Medicare physician payment reform. My name is Vita Ostrander and I am President of the Association. AARP is the nation's largest membership organization of older citizens, representing more than 20 million older Americans.

I commend you and your committee for your leadership on this complex issue. AARP believes that Congress should begin now to bring about change in Medicare's current methods of paying physicians for the following reasons:

1. The establishment of the DRG system for Medicare hospital payment will continue to shift care provision from the inpatient to outpatient setting. If nothing is done to reform Part B, the move towards outpatient care will exacerbate Part B's current spending problems. In addition, beneficiaries' out-of-pocket costs will significantly increase since coverage under Part B is less comprehensive than coverage under Part A.

2. Even with the enactment of a freeze on Medicare payments to physicians, Medicare Part B expenditures will continue to rise at a significant rate, currently projected to be 14% per year through 1988. This rapid rate of increase places pressure on the federal budget, leading policymakers to look for program cuts based upon program savings alone rather than ways to create efficiencies in Part B which would benefit both physicians and beneficiaries.

AARP believes that Congress should begin now to implement

long-term reform in Medicare physician payment and redress current payment discrepancies. My testimony today will address five areas:

1. current problems in Medicare physician payment;
2. beneficiary out-of-pocket liability for physician services;
3. options for reforming Medicare's current method of paying physicians;
4. AARP's views on the freeze on Medicare payments to physicians as adopted in the Reconciliation bill; and
5. the Cabinet Council's recommendation of a capitation system.

Current Problems in Medicare Physician Payment

Total national expenditures for physician services totalled $76 billion in 1984 (an amount representing 20% of national health expenditures) and they have risen by 13% per year since 1971. Growth in Medicare expenditures for physician services has been even more rapid; between 1980 and 1984, such payments rose by 18% annually for a total expenditure in 1984 of $14.6 billion.

Like the Hospital Insurance Trust Fund (HI or Medicare Part A), the Supplementary Medical Insurance Trust Fund (SMI or Medicare Part B) is heading for financial disaster. Part B is the fastest growing federal domestic program with expenditures projected to grow by 14% per year. And while the general revenue financing to the SMI program protects it from insolvency, the rapid infusion of general revenues into the SMI program to meet rising expenditures strains the federal budget, further exacerbating the deficit.

While prices for physician services have been increasing at

nearly twice the rate of general inflation, price alone cannot explain the rapid increases in Part B expenditures. Increasing "intensity of services", as measured by the number of services per enrollee, represents another important contributor to rising Part B costs. Between the 1980 - 1982 time period, increasing intensity accounted for nearly 40 percent of the growth in the Part B program. Any reform in payment policies will have to address not only price increases, but also volume increases.

Beneficiary overuse cannot be linked to increasing Part B expenditures. No study has ever demonstrated excessive or inappropriate use of medical services by the elderly. Each year only 60 percent of beneficiaries use reimbursed physician services. Moreover, the elderly's per capita visits to physicians have remained stable at about 6.5 visits per year since 1970.

It is now generally understood that Medicare's physician reimbursement system which is based upon what physicians customarily charge each year (the CPR methodology) encourages physicians to set higher prices and deliver more services, even though such prices and services may not be warranted in terms of costs and medical appropriateness. Moreover, the CPR methodology has generated numerous discrepancies and anomalies in physician payment such as:

- The gap in compensation for the use of technology and procedures over cognitive services;
- Differentials in reimbursement by specialty, place of service, and geographic location;
- The presence of payment incentives that discourage the treatment of the sickest and frailest segments of the population;

- The presence of payment incentives that encourage the use of expensive hospital care over less costly office-based care.

Beneficiary Liability for Physician Services

While Medicare coverage for hospital services is fairly comprehensive, Medicare coverage for physician services (both in-hospital and out-of-hospital) is less than adequate. Under existing law, Medicare beneficiaries have substantial liability for the cost of physician services. Beneficiaries pay:

1. An annual Part B premium, which totals $186 in 1985 and has risen 116% since 1977;
2. An annual Part B deductible currently $75 which represents approximately $100 in actual out-of-pocket costs since only Medicare "allowable" charges count towards the deductible and the Medicare reduction rate (the amount by which actual charges are reduced by Medicare) is currently 24%;
3. Twenty percent coinsurance of Medicare's "allowable" charges for services which has doubled over the past five years; and
4. Charge reductions associated with unassigned physicians' claims which totalled $2.7 billion in 1984, representing a 100% increase since 1980.

As a result of these charge components, beneficiaries are now responsible for over 60 percent of total physician charges due under Part B.

Under current law a physician may accept or refuse assignment

on a bill-by-bill basis. If he agrees to "accept assignment," he agrees to accept Medicare's reasonable charge determination (20% of which the patient must pay) as payment in full. If the physician refuses to accept assignment, the patient is liable for the same 20% plus the difference between Medicare's reasonable charge and the physician's actual charge.

Approximately 59% of all Part B claims submitted to Medicare for reimbursement at this time are "assigned" compared to less than 50% in 1977. AARP is pleased to note the increase in the assignment rate over the past several years. Nevertheless, beneficiary liability for "unassigned" claims has increased substantially in the past several years, eroding the insurance protection available under Part B for the cost of physician care.

In the absence of comprehensive reform in physician payment, the Association approaches the issue of mandating Part B assignment with caution because of the risk of diminishing the current 59% physician assignment acceptance rate. The Association supports legislation that provides: (1) financial and administrative incentives such as streamlined billing to encourage physicians to accept assignment; (2) "participating" physician programs like those contained in the Medicare Physician Fee Freeze; (3) and the development of regional or local directories that identify physicians who accept assignment. The Association notes with approval HCFA's decision to publish assignment data and has urged HCFA to distribute the information widely in a usable format.

Public and private payments for physician services provided to Medicare beneficiaries now account for almost one-third of total physician expenditures; moreover, Medicare reimbursement to physicians represents on average nearly one-fourth of physician income.

Mindful of these factors, the Association supports mandatory assignment but only as part of a more comprehensive payment system for physicians that establishes rational and fair reimbursement rates.

Physician Payment Reform

Congress took an important first step towards addressing the complex problem of rising physician fees when it enacted the Medicare physician fee freeze. AARP believes that Congress should build upon this initiative and enact legislation which would serve as the basis for the institution of a more rational physician payment methodology. AARP believes that no one payment methodology (DRGs, fee schedules, capitation, etc.) will be appropriate for all types of physician services. While AARP does not endorse at this time a particular mix of payment mechanisms, AARP would like to suggest a number of proposals that could comprise a legislative package for long-term physician payment reform.

Earlier this year the Association commissioned Health Policy Alternatives, Inc. to study the issue of Medicare Physician Payment Reform. I respectfully request the Chairman's permission to submit a copy of this study for the record. The report presents an assessment of the policies and practices used by Medicare to pay physicians for the services they provide to beneficiaries under the program. AARP is still reviewing the legislative proposals outlined in the report. AARP's National Legislative Council will meet in January to establish policy in this area. The Association

does, however, agree with the basic methods underlying the proposals for reform raised in the report.

AARP supports the report's recommendation for incremental implementation of payment reform, both through use of a transition system and by allowing for correction of certain payment problems to take place over a period of time. Thus, reform could be accomplished without unduly sharp or unpredictable reductions or changes in payment levels that could disrupt the continuing availability of physicians' services to beneficiaries.

AARP urges the Committee to consider the following legislative proposals:

1. The establishment of a national Medicare relative value scale (RVS) for physician payment consisting of nationally defined units of services.
2. The development of a standard amount by which to convert the service weights to fees. The standard amount should be indexed to allow updates by a measure of inflation in future years.

3. A mechanism for regular recalibration and reconsideration of service definitions, including a methodology to adjust payments as the cost of technology and services change over time.
4. Improvements in the program's physician participation provisions through practitioner incentives and by enhancing the "prudent purchaser" responsibilities of the government.

The Association suggests a number of other proposals for the Committee's consideration:

1. A mechanism to adjust payment by severity of illness in order to prevent discrimination against care of the frailest segments of the population.
2. A national decision on whether and to what extent medical specialty should affect the payment rate.
3. An allowance for geographic variation in payment related to costs in the geographic location where the service is provided.

The Freeze on Medicare Physician Payments

In recognition of the problem of rapidly rising Medicare expenditures for physician care, Congress enacted a freeze on Medicare payments to physicians as part of The Deficit Reduction Act of 1984. AARP supported the freeze provision because the freeze provided a temporary, but necessary restraint, on rapidly escalating physician fees and contained protection for older persons against the rising cost of physician care. In addition,

the freeze provided clear incentives to encourage the acceptance of Medicare assignment.

This year both Houses of Congress adopted reconciliation proposals which continue to freeze payments to doctors for care of Medicare patients. AARP believes it is important that those doctors who, as participating physicians last year, receive their promised update retroactive to October 1, 1985. Thirty percent of physicians elected to become "participating" under the current freeze, a 10 percentage point increase (the equivalent of a 50% increase) over the previous 20% who agreed to accept assignment in all cases. Not providing the update would break faith with the "participating" physicians. The likely result is a drop in the participation rates and higher costs to beneficiaries. AARP urges the Conference Committee on Budget Reconciliation to provide the promised update in physician fees.

The Cabinet Council's Proposal

Lastly, Mr. Chairman, I would like to comment on the Cabinet Council's recommendation that a voucher system be implemented as the method of physician payment reform.

As I mentioned earlier, AARP does not believe any one payment methodology will be appropriate for all types of physician services. Rather, a mix of payment mechanisms which would assure the quality of care to Medicare patients would be best. Very little research is available upon which to judge the impact of a voucher on Medicare beneficiaries. Thus, the Association is cautious and reserved about the efficacy of a voucher to pro-

vide adequate care to a retired population.

The Association believes that the greatest difficulty in the development of a Medicare voucher system lies in establishing a realistic voucher amount. It is the Association's position that the health status of the individual would have to be taken into account in the calculation of voucher amounts if beneficiaries were to obtain coverage related to their actual needs. However, consideration of health status could not be permitted in setting the health premium charged to the beneficiary; otherwise, those elderly persons with the greatest need for health services--that is, the oldest and sickest beneficiaries--would end up paying the highest premiums.

The Association believes that the key to the success of any voucher proposal is informed consumer choice among competing qualified plans and the ability to choose between a voucher system and the current system. Any voucher plan must contain provisions requiring extensive and specific disclosure of the terms and conditions of coverage provided by participating qualified plans. Further, beneficiaries must be assured access to meaningful and comparative cost, quality, and performance information if they are to make informed health care decisions. Regardless of Congressional action on this issue reform in the fee system will still be needed.

Conclusion

Well-documented problems in Part B expenditure escalation and payment inequities illustrate that reform of Medicare Part B is long overdue. AARP looks forward to working with the Congress to establish a rational and fair method of physician reimbursement that would both encourage the delivery of cost-effective care by physicians and protect beneficiaries against ever-increasing out-of-pocket medical expenses.

Senator DURENBERGER. Thank you very much.

Your testimony urges the committee to consider the establishment of a national Medicare relative-value scale for physician payment, and you have heard the administration's tendency toward some kind of a capitated approach, and you heard some of my questions around my mother. What do you consider the major advantages or disadvantages of a capitated payment system?

Ms. OSTRANDER. Well, first of all we must indicate that a capitated system does not meet everyone's needs; so we must recognize that up front. Your question about the paperwork and the answer is a legitimate one, because the elderly still are finding it difficult. And I find now, in traveling through the country, we are getting new business services of charging fees every 6 months to file claims, which is a little bit on the negative side.

But a capitated system must be good. It must meet certain criteria. And let me say that AARP, in that direction, has provided one piece of educational 1material and is now currently in the process of reevaluating that piece of material. We have also brought not only consumers, we have brought some good HMO's into it to give us some assistance in looking at areas that we must make sure that the educational materials do make clear to the beneficiaries what they need to ask for.

We believe, if that education is going to be profitable, then we must look at all of the angles that must be watched. There are problems still both in enrollment and disenrollment, and those areas still must be addressed.

I think Senator Baucus' question about rural areas is a very legitimate one, because we are seeing some action in that area, and we are hoping that as time goes on we can help erase those problems.

Senator DURENBERGER. Now, the American Association of Retired Persons represents everyone from their 50th birthday on if they sign up, as I well know. And most of us when we buy health insurance in our employed status and buy doctor and hospital coverage, we buy sort of a package of services. And it is only when we reach retirement or eligibility for Medicare that it sort of splits, and we get one policy sort of automatically that covers hospitals, and we get another one that we have to buy into for doctors.

The reality seems to be, with more services, as you indicated in your testimony, moving from hospital inpatient to outpatient, and so forth, that we really ought to be thinking seriously about selling people the same kind of health plan that they used to get when they were employed—in other words, they buy their doctor and their hospital and their medical in one plan.

Does AARP encourage us as a matter of policy to move in the direction of combining hospital and medical services into one choice or one plan from a choice of plans for the elderly in America?

Ms. OSTRANDER. I have some problems with only one plan, because not all elderly would fit into the one plan. I think you yourself talked about one in choices out there. Senator Baucus raised the point about the rural area that may not have the similar access to that.

So I think what we are saying is that we need a mix, and we need mix out there that then people could choose from.

Senator DURENBERGER. What is the current position of AARP relative to catastrophic? Should we be incorporating a catastrophic feature into Medicare benefits?

Ms. OSTRANDER. Perhaps Marty Corry, our legislative representative, could answer that.

Mr. CORRY. Senator, from time to time we have had proposals put before us on catastrophic. First of all, any catastrophic program needs to at least acknowledge that if it only deals with acute care, it is not dealing with the total catastrophic health care cost to the elderly, which is really long-term care. We have another study, which I think the staff has, that addresses some of that, particularly for women.

But second, none of the proposals have been fleshed out to a point that either we were in favor of them or opposed to them. I think only in one case did we have a bill introduced—and I think it was your proposal—with an area with respect to the manner in which beneficiaries are liable, and we did have reservations about it.

We are open to looking at proposals. We have said that to various offices who have "run it by us," so to speak; but we haven't seen anything at this point that we can endorse.

Senator DURENBERGER. All right.

Max Baucus.

Senator BAUCUS. Ms. Ostrander, in your testimony you suggested there be a combination, because different seniors are in different conditions and situations.

Ms. OSTRANDER. That's right.

Senator BAUCUS. I understand that, and I think basically in an ideal world that makes sense. Is there one of the three, though, that makes most sense, or considerably more sense, from your point of view?

Ms. OSTRANDER. That is a difficult question to answer. I think one of the things is that, whatever we look at as a group—and I am talking all of us: Congress, Government, and all—that whatever transition has to take place must be done on a gradual basis, for those very reasons.

We don't know at this point which makes better sense, and I think we do not want to duplicate the traumatic experiences that the elderly have undergone, particularly as we implemented the DRG's and the prospective payment.

I think, in this instance, we need to go through a very slow transition and be willing to recognize when adjustments must be made in that transition.

I don't think any one plan at this point looks more favorable than the others.

Senator BAUCUS. Are you concerned that under the capitation approach, the beneficiaries will get less service? HCFA will have more cost control, they may lower the number of Federal dollars going to the beneficiaries?

Ms. OSTRANDER. One of the concerns that I have on capitation is, and we are talking about an amount of money, that the sicker ones—will they be left out of that capitation system because they

require more care? And then the question of access becomes one for those sicker groups. They will not be as desirable by an HMO to take on.

I think we have to recognize that with the older group, with the population growing faster, that they will be the ones that will need the greater services. If we look at just through HMO's and not a voucher system, how can you build in protection for that group? If you look at the voucher system, then is the group that is sicker going to be charged the highest premium in order to obtain the services they need?

I think you have to be realistic here.

Senator BAUCUS. If we have a combination approach with vouchers, capitation, relative value, DRG, wouldn't that create more uncertainty for beneficiaries? Potentially, the plan that would be provided a beneficiary in a certain area of the country would change, as HCFA might change its mind? For a while it is capitation, and later it is fee-for-service or the relative-value system, and then later a DRG system? That would, arguably, cause more redtape and a lot more uncertainty for beneficiaries. Does that concern you?

Ms. OSTRANDER. I know what you are driving at, and there is no question of it as you get the older group and they become more concerned about their health care. It is just like I said to Mr. Haddow recently: I said, "You are wanting the patients rights at admission, and that's fine; but every time a patient comes into admissions, their frame of mind is such that they are too sick to care about what is up on the board to read."

My concern is, yes, we don't confuse, we don't create uncertainty. But whatever we put out there, one of the things as an association we would say is that there has to be good disclosure about what it has, what it doesn't have, and there must be good education. Without that, in reaching the beneficiaries the confusion will grow and not lessen.

Senator BAUCUS. Senator Dole.

Senator DURENBERGER. Senator Dole.

Senator DOLE. I have no questions, Mr. Chairman.

Senator DURENBERGER. Vita, thank you very much.

Ms. OSTRANDER. Thank you.

Senator DURENBERGER. I appreciate your being here.

Our next panel will begin with Dr. Kevin Fickenscher, president-elect of the National Rural Health Care Association, who comes to us from North Dakota and has to leave quickly. There is only one plane a week to North Dakota, and he has to catch it. [Laughter.]

And Janet Mitchell, president, Center for Health Economics, Chestnut Hill, MA; Dr. Richard Egdahl, the director of the Health Policy Institute, Boston University, Boston, MA; Dr. William Stason, associate professor of health policy and management, Harvard School of Public Health, Cambridge, MA; and Dr. Stanley S. Wallack, director of Health Policy Center, Heller Graduate School of Brandeis.

Senator Dole.

Senator DOLE. Mr. Chairman, I would like to insert a statement in the record and indicate very briefly—because I don't want to hold up any of the witnesses—that I want to commend both you

and Senator Baucus, because I think this subcommittee is getting into an area that has needed some attention for a long, long time.

No one is happy with the current system of physician payment. Physicians and beneficiaries need to know what will and what will not be covered, and we all need to know, since we are really buying it, at what price.

I just suggest that we thought in 1984 that we at least had laid the ground work for some alternative system. We did envision a 15-month physician pay freeze at that time, and now that has been extended; but, frankly, there weren't any viable alternatives available for the short run, and we knew better than to make major changes precipitously.

But I think we delivered a clear message in 1984, and I would only suggest in addition to my statement that the Department must complete their studies, they must provide us with data that will allow us to consider various options for payment reform and not just capitation. Demonstration projects that actually test differing methods of payment, not just capitation, are absolutely essential so that we can avoid making completely uneducated changes.

It would seem to me that, of the three different options, we are going to have to come to some agreement here, or some understanding, and I would hope that we can do that with the invaluable assistance and direction of the chairman of this subcommittee.

Senator DURENBERGER. Thank you very much.

I said before you got here that it was kind of nice to sit in a room full of people who are thinking positively rather than negatively for a change. That is a change over a period of time, and once we made it clear that we were looking for positive thinkers, certainly under your leadership and around this committee, it became much easier to get people to think that way.

So we are really sitting here today making choices among people who are thinking positively about reform, and that is coming a long way in a short period of time.

Well, to the other four of you from the Boston area, I want you to know there is a place called North Dakota, and in western North Dakota they have a big sign as you go in to Max Baucus' State which reads, "Custer was alive when he left North Dakota." [Laughter.]

Then, when you get into Montana and are headed east, the sign says, "A whole lot of people are dying to get out of North Dakota." [Laughter.]

With that we will introduce the director of the Rural Health Division of the University of North Dakota, Kevin Fickenscher.

STATEMENT OF KEVIN FICKENSCHER, M.D., PRESIDENT-ELECT, NATIONAL RURAL HEALTH CARE ASSOCIATION, KANSAS CITY, MO

Dr. FICKENSCHER. Senator Durenberger, Senator Dole, it is a distinct pleasure to be here, not only because of the opportunity to present testimony on rural health but also to get some respite from the weather in North Dakota. I also want to thank you for allowing me the opportunity to speak early and catch a plane to North

Dakota; since deregulation it has gotten increasingly difficult to get back home.

Senator DOLE. You ought to talk to the Secretary of Transportation about that. [Laughter.]

Dr. FICKENSCHER. You might want to pass that along to her. I appreciate that. [Laughter.]

Of course, that is a hearing for another time, perhaps.

I am pleased to be here to share with you the rural perspective on the important issues related to Medicare reimbursement for rural services. On behalf of the rural providers throughout the Nation, we sincerely appreciate the opportunity to share our ideas with you on this very important issue.

But before proceeding, I just briefly want to share with you some of the differences that I think exist between urban and rural areas. I know both of you are very sensitive to this, because you come from rural States.

In many respects, ruralness is a state of mind, and it differs throughout the country. The ruralness of Minnesota and North Dakota and Wyoming and places like that is markedly different from the ruralness of Delaware, New Jersey, and other places in the East and in the Far West. Yet, from our perspective there is a common weave to the fabric of rural America which highlights many common strengths and weaknesses, and in my prepared testimony I have highlighted those, but because of the impending departure of my plane I won't go into a lot of detail.

I think it is important to consider those strengths and weaknesses as we look at some of the issues related to rural health care and as a way of demarcating the distinct differences of rural areas from urban areas.

One in four Americans, one in three elderly, and over half of the Nation's poor reside in rural America, as defined by the Bureau of the Census. Although these groups do not represent a distinct majority, they clearly represent a sizable proportion of the population whose interests need to be represented in policy decisions.

It is our experience that decisions made here in Washington relative to a whole host of issues, including Medicare, generally do not consider the impact on rural areas. Because rural areas in general have a larger percentage of their populations who are elderly or impoverished, changes in the reimbursement system that we are discussing today impact more directly on the type and level of services that are provided by rural physicians. In fact, a study was completed in 1977 by Davis and Marshall which concluded that the Federal reimbursement program systematically discriminates against rural residents and providers and acts as impediments to a more equitable distribution of medical services.

Several States such as North Dakota have independently received approval to adopt such a policy of change so that they can have unified State systems for Medicare reimbursement. Other States, such as Alabama, have not done this, and the inequities of rural reimbursement differential continue.

There are other factors which I also believe exist that can magnify the pre-existing variation in allowable charges for given procedures. It seems obvious to me as an individual who is involved in rural health care that physicians with the same training, certified

by the same boards, providing the same types of service with the same liability for the same type of problem should be compensated at the same level. And really, that is what we are talking about when we are talking about reimbursement for rural physicians.

Under the current system, however, many rural physicians are compensated at a level far below that of their urban counterparts.

We are not suggesting that the existing Medicare fee-for-service reimbursement system be discarded; in fact, there are advantages and disadvantages with that system, and they have been highlighted in multiple testimony before your committee, and I don't intend to get into that.

I think what I would rather do is highlight the issues or the six criteria that we in the National Rural Health Care Association believe are important in looking at rural health care.

The first one is geographic equity. Any payment system should provide equity in reimbursement among all physicians for a given service. In our estimation, there is simply no rational justification for continuing the current inequity between urban and rural rates for physician payments. Often it is argued that rates are higher in urban areas, and in fact that is not the case. And to make such an assumption is to assume that nothing has changed in rural America in the last 25 years. In fact, in this last issue of Medical Economics, which is the best information that is available to us, the November 1985 issue, it is revealed that the average total cost for rural physicians and urban physicians were essentially identical, that there was very little difference. And in fact, as a percent of overall growth income, the overall costs for rural practices were higher than those of suburban and urban practices.

It is clear from these figures, which were just released this last month, that the supposed urban-rural differential in fact does not exist; and if we were to shift the discussion to access, one could even suggest that physicians who practice in rural and remote areas should perhaps receive a bonus for practicing in those areas as well.

The second issue is specialty equity. Any physician who is qualified to perform a service should be reimbursed in an equivalent amount regardless of their specialty. From my experience, a rural board-certified family physician performing a physical examination, a proctoscopic examination, or interpreting a Holter monitor should be paid the same as an internist, or a gastroenterologist, or a cardiologist conducting the same type of service. Each of these examinations are considered basic training for primary care physicians and are inherent skills in practicing quality medicine. To reimburse one specialty at a higher level than another implies that the procedure is reimbursed based on particular prerequisites of that specialty.

Senator DURENBERGER. You are going to have to catch your airplane.

Dr. FICKENSCHER. I know. Three more points, and then I will quit, OK?

Senator DURENBERGER. All right, go fast.

Dr. FICKENSCHER. The third one is service equity. I think it is important for physicians that we consider the cognitive skills as equal to procedural skills.

The fourth one is incentives. We favor a reimbursement system that provides incentives for high-quality community based practice and are not necessarily adverse to capitation; we just feel it needs to be studied, and the implications looked at as it relates to rural areas.

And then access, that any system needs to consider access in dealing with health care. And unfortunately that has been a major problem in rural areas; it is a continuing problem. There is a physician surplus. But I-can tell you that it exists in Washington, DC, it is in Minneapolis and in New York, but it is not in rural North Dakota, and it is not in rural Kansas and rural Montana.

I think that the type of reimbursement system that we consider needs to take those kinds of issues into consideration.

Thank you very much. I appreciate the opportunity of presenting before you today.

Senator DURENBERGER. Thank you very much, and we will permit you to be excused from the panel.

Senator DOLE. If you would like some light reading, here is a copy of the tax bill, if you want to read it on your way home. [Laughter.]

Dr. FICKENSCHER. I'll take that on the plane.

Senator DOLE. It's only 184 pages.

Senator DURENBERGER. That is right. They will charge him extra to take it on the plane.

Our next witness is Dr. Janet Mitchell.

[Dr. Fickenscher's written testimony follows:]

RURAL CONSIDERATIONS IN MEDICARE REIMBURSEMENT POLICY FOR PHYSICIAN SERVICES

Kevin M. Fickenscher, M.D.
President-Elect, National Rural Health Care Association
Director, Office of Rural Health
School of Medicine
University of North Dakota
Grand Forks, North Dakota

Statement before the
Subcommittee on Health
Senate Finance Committee
Washington, D.C.
December 6, 1985

Mr. Chairman and Members of the Finance Committee:

Thank you for inviting me to share the "rural perspective" on the important issues related to Medicare reimbursement for physician services. My name is Kevin Fickenscher. I am a board-certified, Assistant Professor of Family Medicine at the University of North Dakota School of Medicine; and, Director of the North Dakota Office of Rural Health. Over the past five years I have worked extensively with rural hospitals, physician's practices and communities in evaluating approaches for sustaining local, quality primary health care services in fourteen of the Midwestern and Western states. It is my distinct privilege and honor to share the "rural perspective" with you as President-Elect of the National Rural Health Care Association, a multi-disciplinary association of health care professionals involved in all aspects of rural health delivery throughout the country. We are an association concerned with maintaining equity in our health care system for people in all areas, rural and urban.

On behalf of rural providers throughout the nation, we appreciate the opportunity to share with the members of the Committee concerns related to the Medicare physician payment system. However, before proceeding, I would like to briefly share some thoughts on the differences between rural and urban areas. In many respects, ruralness is a state of mind. The rural areas of Minnesota, North Dakota, Montana and Wyoming differ appreciably from those of Delaware and New Jersey. Yet, there is a common weave to the fabric of rural America which highlights common strengths and weaknesses (See Table I) regardless

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TABLE I.

A COMPARISON OF RELATIVE STRENGTHS AND WEAKNESSES FOR URBAN AND RURAL COMMUNITIES

	RURAL	URBAN
Strengths	Cohesiveness	Scale
	Established interdependence	Availability of resources
	Access to local government	More stable economy
	Strong work/self-sufficiency ethic	Adaptable to change
	Strong informal support network	Diverse population base
	Mutuality	Diverse income levels
	Fundraising	Availability of professionals
	Providers mutually supportive	
Weaknesses	Lack of critical mass	Lack of cohesiveness
	Skewed population demographics	Limited access to government
	Fluctuating economy	Limited informal support network
	Resistance to change	Laissez faire attitude
	Transportation problems	No interdependence
	Shortage of professionals	Competition among providers
	Lack of resources	Competition for fundraising
	Lower average income	

of geography. Rural America possesses a number of weaknesses that impact directly on the type and level of health care services provided in rural communities. These include: 1) lack of critical mass to support selected programs and services, 2) a fluctuating economy due to the inherent dependence upon agriculture in local communities, 3) transportation difficulties due to the lack of public systems, 4) a shortage of professionals despite excellent opportunities in rural areas and, often, excess supply in urban areas of the country, 5) lower average income for the rural population as a whole, 6) skewed population demographics with a relatively larger percent of population over age 65 and a concommitant decline in the young, active working-age population; and, 7) other factors which adversely impact on the delivery of health care services.

Despite these difficulties, rural America has inherent strengths which make creativity and change more feasible at a time when our health care system needs these attributes. Specifically, rural communities possess an established interdependence and cohesiveness in attempts to resolve problems. These characteristics allow for greater mutuality in identifying barriers to sustaining services and programs related to rural health care. Rural people have greater access to local government which and sustains a mutually supportive network between the five critical sectors of rural America: education, commerce, health, religion and government. Unlike urban areas of the country where services operate more independently these five sectors must cooperate in the rural communities to sustain an array of local services including health care.

I highlight the relative strengths and weaknesses of rural areas as a way of demarcating the distinct differences from urban areas. One in four Americans, one in three elderly, and over half of the nation's poor reside in rural America as defined by the Bureau of the Census. Although these groups do not represent a majority, they clearly represent a sizeable proportion of the population whose interests need to be represented in policy decisions.

It is our experience that decisions made in Washington relative to a host of issues including Medicare payments generally do not consider the impact on rural areas. Because rural areas, in general, have a larger percentage of their populations who are elderly or impoverished, changes in the system impact more directly on the type and level of services provided by rural physicians. A study completed in 1977 by Davis and Marshall concluded that Federal reimbursement programs systematically discriminate against rural residents and providers; and, acted as impediments to a more equitable distribution of medical services. In fact, a task force commissioned by then Secretary Califano came to similar conclusions that the policy of differential rural and urban Medicare payments was inconsistent and inequitable. The task force recommended that each state be considered a single "charge area" for Medicare payment. Several states (e.g. North Dakota) have adapted such a policy although may other states (e.g. Alabama) continue the inequities of a rural reimbursement differential. Now nearly ten years later, little has changed except that the gap between urban and rural rates of payment appears to be widening

These inequities continue to contribute to considerable variation in the Medicare program from region to region based upon the authority held at the intermediary level. The major difficulty with the individual Medicare carrier is the discretionary authority on the application of whether or not rural and urban physicians are to receive the same fee for the same procedure. These and other factors can magnify the pre-existing variation in allowable charges for given procedures. It seems obvious that physicians with the same training, certification by the same board, providing the same service, with the same liability, for the same problem should be compensated at the same level. Under the current system, however, many rural physicians are compensated at a level far below that of their urban counterparts sometimes as little as half as much.

One of the inherent difficulties with the current Medicare reimbursement system is the application of the "usual, customary and reasonable" (UCR) fee system. The application of the UCR system under Medicare has resulted in the institutionalization of capricious differences among urban and rural physicians related to fees for given procedures. Lynn Etheredge in a paper entitled: "Medicare - Paying the Physician: History, Issues and Options" from March, 1983, cites multiple differences between the high and low prevailing Medicare charges. Although the examples cited in Table II relate to charges, in general, indepth analysis of the data would reveal that the lower fees schedules are disproportionately represented by rural physicians.

We are not suggesting that the existing Medicare fee-for-service reimbursement system be discarded. In fact, there are advantages

TABLE II.

HIGH AND LOW PREVAILING MEDICARE CHARGES

Procedure/Fee Screen Year	High	Low	Ratio
1. Brief follow-up visit by internist			
1976	$18.18	$6.70	2.71:1
1980	33.10	7.00	4:73:1
2. Extraction of lens by an Ophthalmologist			
1976	900.00	412.56	2.18:1
1980	1,390.70	536.50	2.59:1
3. Electrosection of prostate by a urologist			
1976	862.70	356.46	2.42:1
1980	1,410.40	475.25	2.97:1
4. Hysterectomy by an obstetricain/ gynecologist			
1976	850.00	450.00	2.13:1
1980	1,305.20	536.50	2.43:1
5. Chest x-ray single view by a radiologist			
1976	25.00	4.00	6.25:1
1980	35.00	5.50	6.36:1

Source: HCFA "Medicare Part B Charges, Overview and Trends, Fee Screen Years, 1976-1980, Feb. 3, 1982, pp. 44-48.

Cited in Lynn Etheredge, "MEDICARE: PAYING THE PHYSICIAN, History, Issues and Options," Mimeographed, March, 1983.

and disadvantages (See Table III) for each of the reimbursement systems currently under examination by the Committee, the Health Care Financing Administration, and others at all levels of government. Professor Uwe Reinhardt of the Department of Economics and Public Affairs at Princeton University has described the advantages and disadvantages of each reimbursement systems in numerous papers and lectures. It seems probable that we in this country will have a pluralistic system of physician reimbursement that may well include elements of all of the systems under discussion.

The current debate on Medicare physician reimbursement revolves around the relative merits of: 1) a modification of the fee-for-service system through the use of fixed fees and possibly relative values scales; 2) a physician diagnostic related group system; or, 3) a capitation mechanism. You have received substantial testimony on the relative merits and demerits of each of these systems. Rather than provide you with a comprehensive analysis of each potential system, I would like to share with you criteria to be considered that relates to rural providers for all of the proposed systems. The National Rural Health Care Association strongly suggests that the various reimbursement methodologies should be judged against the following six criteria, or values, that are important in providing equity and assuring continued access to rural health care systems:

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TABLE IV

OVERHEAD COSTS OF PHYSICIAN PRACTICES, [illegible]

	URBAN	SUBURBAN	RURAL	FAMILY PRACTICE	GENERAL PRACTICE
Office Payroll	$28,050	$30,550	$28,640	$33,560	$26,650
Space	$12,180	$12,030	$9,220	$10,640	$8,480
Malpractice	$5,650	$5,220	$4,720	$3,560	$3,470
Drugs/Supplies	$3,930	$5,520	$6,000	$6,470	$5,780
Depreciation /Equipment	$6,600	$7,630	$6,950	$7,020	$5,380
Continuing Education	$2,000	$2,000	$2,000	$1,500	$1,000
Miscellaneous/Other	$3,400	$3,500	$5,800	---	---
TOTAL	$61,810	$66,750	$63,330	$62,750	$50,760

Source: Medical Economics, November 11, 1985

1. Geographic equity. Any payment system should provide equity in reimbursement among all physicians for a given service. There is simply no rational justification for continuing the current inequity between urban and rural rates for physician payments. One of the arguments frequently cited in support of higher urban payment rates is that practice costs are higher in urban areas, but such an argument is not supported by fact. Too make such an assumption is to accept the notion that nothing has changed in rural America in the last twenty-five years. Having lived in New York City and in North Dakota, I can assure you that the cost of eggs in the country are the same as in the city. In fact, the November, 1985 issue of Medical Economics, revealed that the average total practice costs for rural practices are

greater than the costs of urban practices. (See Table IV). Overall professional expenses for suburban medical practices were only about five percent higher than the costs that rural practices. Additionally, as a percent of overall income, the highest overall costs were associated with rural practices (39.8%), followed by suburban practices (38.8%); and, finally, urban practices (36.9%).

At least partially because they are paid at lower rates, rural physicians see about 20% more patient visits than their urban counterparts and work more hours. In many areas of the country they are further hindered by the absence of a substantial, procedure-based hospital practice, which for urban physicians represents nearly 30% of their overall income - an income where the overhead expense is not covered by the practice but by the hospital. It is clear from these figures - which were released in the last month - that the supposed urban-rural differential for practice overhead costs does not, in fact, exist. If we were to shift the discussion to "access", one could even suggest that physicians practicing in both remote rural areas and inter-city urban areas should receive a bonus for their selection of those sites for their prac'ices because of cost and commitment.

2. Specialty equity. Any physician qualified to perform a service should be reimbursed an equivalent amount regardless of their specialty. A rural, board-certified family physician performing a physical examination, a proctoscopic examination or interpreting a Holter monitoring should be paid the same as an internist,

gastroenterologist or cardiologist conducting the same examination or test. Each of these examinations are considered basic training for primary care physicians and are an inherent skill in practicing quality medicine. To reimburse one specialty at a higher level than another implies that the procedure is reimbursed based on particular pre-requisites of that specialty. In our estimation, the pre-requisites these types of primary care procedures are equivalent between the specialties.

3. Service equity. Physician services which require cognitive skills should be given an equivalent value to those services requiring procedural skills. Current physician payment rates are skewed heavily in favor of procedural services and high technology applications. As a result, physicians in the medical specialties and subspecialties which tend to practice procedure-oriented care receive disproportionate reimbursement for the degree of services rendered. As a case in point, a rural family physician from South Dakota and I were recently discussing this issue. The physician indicated that he had recently seen a patient with an upper respiratory complaint and performed a physical assessment with appropriate lab work. He also ordered a chest x-ray as a diagnostic aid. The family physician then interpreted the lab findings, read the x-ray, made his diagnosis, communicated his instructions to the patient and for the nearly one-half hour of effort received a $16 payment. Later in the week, the consulting radiologist visited his clinic and spent several minutes "over-reading" the chest x-ray taken on the patient and received

$15 for her effort. The inequity is obvious.

It is our contention that the rural physician's skill in soliciting information from the patient, diagnosing the difficulty and treating the patient's problem were of significantly more overall value to the health of the patient than the radiologist's brief encounter with the x-ray film. The current reimbursement system is based on an archaic model when the physician's armamentarium was often limited to a few procedures. Contemporary medicine has given us new approaches to health care that are not procedural and require careful analysis of information and the examination of patients.

4. Incentives. The National Rural Health Care Association favors a reimbursement system that provides incentives for high quality, community-based practice that encourages appropriate utilization of services. One of the problems of the current fee-for-service system is that it does not reward ambulatory and preventive medical practice which may keep people well and out of the hospital. The extra time spent by a physician on patient education usually with no compensation of results in a savings for the patient or the insurer. Capitation systems tend to reward this type of practice behavior by giving the provider a payment which is "vertically integrated."

5. Access. Any system of payment for physicians' services should maintain or improve access for the disadvantaged, the elderly, the handicapped, the poor and the unemployed. Our early reports on the hospital Prospective Payment System seem to show that

access for the poor was not helped by the implementation of the DPG payment mechanism. In addition, the special needs of very remote, or "frontier" areas, should be taken into account. It is one thing to put the financial clamps on physicians in an over-doctored area like Minneapolis or Trenton or Washington, D.C. It is quite another thing to indiscrimately squeeze the small group practice in Carollton, Alabama; Terry, Montana; or, Lusk, Wyoming.

6. Simplicity. The current Medicare payment system is a complex maze of rules, regulations, policies and interpretations that foils all but the most dedicated or the most fortunate. We recognize that any bureaucratic system must have rules by which it is administered in order to make it fair, but we respectfully request your consideration of rural people and their providers who are dependent on the system for their care or their livelihood. Rural practices do not have full-time fiscal managers, accountants, medical records technicians, billings clerks and lawyers which interpret and respond to the results of your deliberations. The complexity is made worse by the differing interpretations often obtained from different intermediary staff at different times of the day.

In closing, it is time to end the inequity in payments to rural physicians once and for all. There is little, if any, justification for paying rural doctors less for the same service than their urban counterparts. All of the primary care specialties, but especially Family Practice since the bulk of rural providers are of this specialty,

should be reimbursed at the same rate as other specialties. Cognitive services should be at least as highly valued as procedural services. Payments to physicians should encourage appropriate use of services and should maintain access for the indigent. Finally, every effort should be made to simplify the system, to allow the rural health system's scarce energies and resources to be allocated to providing care rather than filling out complex claims forms.

It is a cruel irony that the federal government recognizes the need to provide health services and resources to medically underserved populations through the strong and vigorous support of the National Health Service Corps, the Community and Migrant Health Centers Programs, and the Indian Health Service; and, yet, rewards those physicians who practice in such areas with lower reimbursement rates. Such schizophrenia is further compounded by the major problems of our state Medicaid programs which follow Medicare's lead related to reimbursement policy. Our federal Medicare reimbursement policy should reflect and support the federal access policy for rural areas to assist us in resolving the manpower shortage problems that still linger in rural America.

Thank you for the opportunity to testify on behalf of the membership of the National Rural Health Care Association on this issue of vital importance to rural America.

STATEMENT OF JANET B. MITCHELL, PH.D., PRESIDENT, CENTER FOR HEALTH ECONOMICS, CHESTNUT HILL, MA

Dr. MITCHELL. Thank you, Senator Durenberger and Senator Dole, for inviting me to speak with you today. I have been studying physician DRG's somewhat intensively over the last couple of years, and I am delighted to be able to talk with you about them.

Physician DRG's are identical in concept to DRG payment under the Medicare prospective payment system—a single fixed payment for all inpatient services. There is one major difference, though, in that they package together services for multiple physicians who normally bill separately.

What are the advantages to physician DRG's over our current fee-for-service system? Well, first of all, they simultaneously control both the price paid to physicians and the number of services.

Under our current system, physicians bear no financial risk in ordering tests or requesting assistance during surgery. They use services from other physicians in their treatment of patients without having to pay for them. The financial burden is borne wholly by the Medicare Program and by the beneficiary.

Physician DRG's would encourage physicians to cut back on marginally necessary procedures like x-rays and consultations, since their cost must come out of the fixed payment.

Second, physician DRG's are a relatively nonintrusive approach to controlling utilization. For example, there is some concern over the excessive use of assistant surgeons, and this has led to legislative proposals disallowing any Medicare reimbursement of assistants during lens procedures. I find this a somewhat cumbersome regulatory approach.

Physician DRG's, on the other hand, lets primary surgeons use their own judgment. It allows them to determine what mix of services they will use—within the financial constraints, of course, of the case payment.

Third, physician DRG's would help reduce unwarranted geographic variations. My work has shown, for example, that a Medicare patient is two to three times more likely to receive a specialty consultation in New Jersey than a patient with the identical illness in North Carolina. Using national physician DRG weights, just like Medicare PPS does, would help reduce these disparities.

And finally, physician DRG's would build on the prospective payment system now in place for hospital care by more closely aligning the incentives of physicians and hospital administrators.

But if DRG-based payment for physicians has one major shortcoming, it is the DRG's themselves. The DRG classification system does a poor job of explaining physician or hospital costs from medical cases—that is, for nonsurgical admissions.

Now, while better case-mix measures are clearly needed, adjustments such as those used by PPS can help compensate, that is, extra payments for outliers, indirect medical education, et cetera.

A critical question is: Who would receive the DRG payment? Do we pay the individual physician responsible for the admission, or some other entity?

Any case payment system like physician DRG's involves averaging across more complex and less complex cases, but averaging re-

quires that you have enough admissions to make the law of large numbers work.

Many attending physicians, as Dr. Desmarais testified this morning, have small Medicare inpatient caseloads, and DRG payment would be a lottery.

An alternative is to pay the hospital medical staff, who of course have large numbers of Medicare admissions. The organization of the staff and the distribution of physician payments might resemble an IPA, an independent practice association.

Now, under physician DRG's, medical staffs would be at financial risk, just as hospitals are now under the Medicare prospective payment system. But the whole concept of risk sharing is undermined if the staff is allowed to make assignment decisions on a case-by-case basis. Assignment would be taken on the easy cases and not accepted on those expected to be more difficult.

A solution would be to treat inpatient physician services just like Medicare handles hospital care—the DRG rate would represent payment in full for all inpatient services, with the beneficiary liable only for any deductible or coinsurance. This means, of course, that the medical staff must sign a Medicare physician-participation agreement as a group.

There are a number of other packaging alternatives that are described in my written testimony that are somewhat less comprehensive than physician DRG's but might be more easily introduced into our current fee-for-service system, and I would be happy to discuss those at a later time if there is any interest.

Thank you.

Senator DURENBERGER. Janet, thank you very much.

Dick Egdahl.

[(Dr. Mitchell's written testimony follows:]

DRG-BASED CASE PAYMENT FOR INPATIENT PHYSICIAN SERVICES

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Statement before the United States Senate Committee on Finance
Subcommittee on Health; Hearing on Medicare Physician Payment.
Washington, D.C.
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Introduction

My name is Janet B. Mitchell. I am the President of the Center for Health Economics Research, a non-profit research firm in Chestnut Hill, Massachusetts. Much of my research during the past decade has been devoted to issues of physician reimbursement under Medicare and Medicaid.

I would like to thank the Committee for inviting me to testify on the possible use of DRG-based payment for Medicare physician services. I have studied the feasibility of "physician DRGs" intensively over the past two years and am pleased to share my thoughts on this issue with you.

The Problem is Volume, Not Fees

Only a small part of the escalation in Medicare expenditures for physicians' services is attributable to physician fee increases, above and beyond economy-wide inflation. Eight out of every ten added dollars are due to growing utilization and service intensity, e.g., more surgeries per hospital stay, more lab tests, more in-hospital visits per admission. This happens in three ways: unpackaging of physician services, procedure code inflation, and the involvement of multiple physicians.

Unpackaging is the practice of submitting an itemized bill for every service performed; like ordering a la carte from a restaurant menu, the total charge is invariably higher. Examples include charging separately for post-operative visits instead of including them with the fee for the surgery itself, or charging separately for each lab test rather than including them in a global office visit fee.

Procedure inflation is the practice of billing under a more complex and expensive procedure code for the same service. This is particularly likely to occur as the number of categories grows larger and the distinctions

between them become blurred. In 1965 physicians could bill one of 2,000 codes for a given service; they now have over 6,000 to choose from.

Finally, Medicare expenditures for physicians' services are increasing in part because of the sheer number of physicians involved during a single episode of illness, all of whom submit independent bills. Take a routine surgical admission, for example. Besides the surgeon and the anesthesiologist, there may be an assistant surgeon, a radiologist, a pathologist, and a variety of consulting specialists, as well as the patient's personal family physician providing routine hospital visits. These routine visits, of course, are <u>in addition to</u> the follow-up care that is to be provided by the surgeon who performed the operation.

Traditional cost control approaches like fee freezes will <u>not</u> curb these sources of expenditure increases, and could actually exacerbate them. Effective cost control can only be achieved by controlling prices <u>and</u> the number of services simultaneously, and this requires an innovative approach to reimbursing physicians.

How can this be done? One solution is to "package" physician services, to re-define the payment unit from a narrow procedure to a more comprehensive bundle of services.

<u>The Case for Physician DRG Payment</u>

HMOs, of course are the ultimate package; all physician and hospital services are bundled together and a single payment made. While capitation is certainly the preferred payment option, it remains a longer-run solution. There are a number of packaging approaches, however, that are less comprehensive than HMOs but which might be more easily incorporated into the current fee-for-service reimbursement system. One approach is to package all inpatient physician services into a single payment; this has become popularly known as "physician DRGs" or "MD-DRGs".

What exactly is a physician DRG? What I mean by physician DRGs is a prospective payment system for inpatient physician services, much like that currently used by Medicare for inpatient hospital care. A fixed case payment per hospital admission is made, where the size of the payment is determined by the patient's DRG. Under this approach, all services performed by physicians and normally billed as Medicare Part B services would be combined in a single bill, and a single payment made. Surgeons have traditionally been reimbursed on a package basis, receiving a single payment for both the operation itself and routine postoperative care. Physician DRGs go a step further by packaging all other physician services provided during the hospital stay, such as anesthesia, x-rays, and consultations.

Physician DRGs have several important advantages for payment purposes. First, they simultaneously control both the prices paid to physicians (the DRG rate) and the number of services. Second, they are a nonintrusive approach to controlling volume. Third, physician DRGs would reduce unwarranted geographic variation in service use. Fourth, they build on the prospective payment system now in place for hospital care. Let us examine each of these in more detail.

The major advantage to physician DRGs is that they encourage the physician to take a broader view of the patient care process, with incentives to cut back on marginal procedures. Under the current reimbursement system, the physician bears no financial risk in ordering diagnostic tests or requesting assistants during surgery. He/she uses the services of other physicians in his/her treatment of the patient without having to pay for them. The financial burden of this care is borne wholly by the Medicare program and the beneficiary. Physician DRGs would encourage physicians to cut back on marginally necessary x-rays or consultations, for example, since their costs must come out of the fixed case payment.

Physician DRGs are also less intrusive in that responsibility for monitoring utilization rests with the individual physician rather than with an outside agency. Some institutional safeguards, like PROs, would clearly remain necessary, but a cumbersome regulatory approach could be avoided. Rather than regulations dictating that assistant surgeons could never be reimbursed for lens procedures, for example, DRG payment would allow the primary surgeon to use his or her best judgement. This approach recognizes that patients vary in casemix complexity and gives the attending physician the flexibility to make decisions on a patient by patient basis within the financial constraints of a fixed case payment.

My studies have documented tremendous unexplained geographic variation in discretionary services like assistant surgeon and consultation rates. This is true even within very narrowly defined DRGs, such as lens procedures and major joint surgery, where rates vary two-three fold from one state to another. Differences in physician practice patterns have financial implications far beyond their nominal costs. The decision to call in a consultant, for example, raises total physician inpatient charges, not only because of the consultant's fee, but also because of the additional tests he or she may order. These added tests, and the longer stays that may ensue as a result of them, drive up total hospital costs as well. The use of national physician DRG weights, like those currently used in Medicare hospital reimbursement, would eliminate these geographic disparities.

Finally, physician DRGs would build upon the hospital prospective payment system by more closely aligning physicians' incentives with those of hospital administrators. I know that physicians have voiced the notion that the current fee-for-service payment system acts as a "check and balance" on the skimping incentives in Medicare's hospital PPS. This "watch dog" function could be undermined if physicians were also reimbursed on a DRG

basis. This view implicitly assumes that an adversarial relationship is necessary to assure quality care, a view I categorically reject, for two reasons. First, under a global fixed payment, both hospitals and physicians would be competing for patients primarly on the basis of quality, a competition heightened dramatically in recent years by declining admissions. Second, I reject the notion that any untoward incentives of PPS can, and should, be offset by continuing to permit physicians totally free access to all of the hospitals' staff, including other physicians.

Limitations of the DRG Classification System

If the idea of DRG-based payment for physicians has one major shortcoming, it's the DRGs themselves. Although the DRG classification system can predict average Part B charges quite well for surgical admissions, it performs poorly for medical cases For those patients not undergoing surgery, the DRG averages will be of little value in describing expected physician resource use.

Does this mean that the DRG system is not adequate for physician reimbursement? Not necessarily. As a matter of fact, my research shows that DRGs do not do any better job of predicting hospital costs, yet despite this, DRG-based payment has been generally acknowledged a success, probably for two reasons. First, hospitals are able to average large numbers of admissions across all the medical DRGs, offsetting large losses on a few very sick patients with small gains on the majority of healthier patients. Second, PPS includes a number of adjustments, including extra payments for outliers and indirect medical education, that help capture unmeasured sources of casemix variation. Presumably, similar adjustments could be made for physician DRGs, so that physicians would not have to bear all the risk.

Nevertheless, a system which reimburses differentially for classes of patients who statistically are no different in terms of resource use may send the wrong signals to hospital and physician decisionmakers. New and ongoing research into ways of refining the DRGs to better measure severity of illness should continue.

Whom To Pay?

Under the current, fee-for-service reimbursement system, each physician bills, and is paid separately for his or her services. A key question is who would receive the DRG payment under a system that would package the services of many physicians together. Two primary payment models have been identified: direct payment to the attending physician; and payment to the medical staff.

My simulation analyses have clearly shown that payments to individual attending physicians would be a lottery, with inequitable losses for some physicians and windfall gains for others. This results largely from the small Medicare inpatient caseloads for many physicians. Any case-payment approach, such as physician DRGs, involves some sort of averaging. It is assumed that some admissions will require more physicians' services and others will require less, but that on average the DRG payment is a reasonable reimbursement for the services provided. Averaging, however, requires sufficient numbers of admissions in order for the law of large numbers to work. In general, the fewer cases admitted by a physician, the higher the likelihood there is of random bias. The randomness introduced by small inpatient caseloads is exacerbated by the varied range of DRGs treated by individual physicians (producing even fewer admissions within any one DRG) and by the inadequacy of the medical DRGs themselves.

Given the potential for unacceptably large losses for individual attending physicians, an alternative is to pay the hospital medical staff. Because of their high volume of cases, there should be greater opportunity for risk pooling and for the averaging principle to work, just as it does under the hospital PPS. In fact, per case gains and losses are calculated at the same level as hospital PPS.

Although there are many ways in which the Part B carrier could pay staff members, it is probably easiest to conceptualize the hospital medical staff as an Independent Practice Association (IPA) for reimbursement purposes. The carrier would credit a total medical staff account based on the actuarial value of each physician DRG, while accumulating individual physician billings in separate accounts. Periodic disbursements from this account would be made to individual physicians based on either actual billings or number of services. When total medical staff credits deviate from the sum of individual accounts, disbursements would first be pro-rated. A typical IPA method would hold back a small percentage of DRG payments to produce a bonus pool. The medical staff presumably would allocate bonuses based on individual physician contribution to the overall staff goal of cost control, i.e., staying within the DRG allowables.

At the present time, hospital medical staffs are generally not constituted as legal entities empowered to receive and distribute physician payments. Some amount of start-up time would be required to enable staffs to reconstitute themselves as payment organizations and to develop algorithms for bonus allocation. Members of the medical community at large have recently shown remarkable flexibility and versatility in the speed with which they have developed and joined IPAs, HMOs, PPOs and the like. Given the large dollars at stake, I would not expect this re-organization to be a major problem in the implementation of DRG-based case payments for physicians.

Medicare Participation Agreements for Physician DRGs

Once we move from fee for-service to package reimbursement for physician services, we must reconsider the meaning of assignment. Under any packaging arrangement like physician DRGs, medical staffs are at financial risk. If the case is more complex than the DRG average or if the attending physician utilizes more services than average, the staff will "lose money", i.e., the DRG payment will be less than actual billings. On the other hand, if the case is less complex or receives fewer physician services than the DRG average, the staff will receive a payment greater than billings and can retain the difference (or profit). The whole concept of risk-sharing for physicians is undermined, however, if the medical staff is allowed to make assignment decisions on a case-by-case basis. Assignment would be taken on the easy admissions and not accepted on those expected to be more difficult. Such an outcome would leave the Medicare program with the worst of both worlds: paying the physician considerably more than necessary when the case is assigned, and the beneficiary paying considerably more out-of-pocket when it is not. The net effect is an income transfer from beneficiaries to physicians although the government's outlays are unaffected.

The solution would be to treat inpatient physician services just like Medicare handles hospital care: the DRG rate would represent payment-in-full for all inpatient care, with the beneficiary liable only for any deductible and coinsurance. This means, of course, that the medical staff must sign a Medicare physician participation agreement as a group.

Some Other Packaging Alternatives

Paying physicians on a DRG case basis represents a major departure from the current fee-for-service reimbursement system, but so too was the hospital PPS from cost-based reimbursement. It is only with sweeping reform that we can expect to check the growth in expenditures for physician services. Nevertheless, Congress may decide that this is not yet the time for such a step. Are there alternative packaging arrangements that are narrower in scope but possibly more acceptable to physicians and easier to implement in the short run? Yes, first of all, Part B radiology, anesthesia, and pathology services could be redefined as hospital services and paid through Part A under the current prospective payment system. (Recalibration of the PPS cost weights to include these other services could be easily accomplished.) Since patients do not choose their own radiologist, anesthesiologist, or pathologist, and hence can not shop based on price (or willingness to accept assignment), it seems more appropriate to include these physicians' services in the hospital bill.

A second alternative would be to base the package on a specific procedure, rather than a DRG. What we call a special procedure package would consist of all related components of a diagnostic or therapeutic procedure, including the services of all involved physicians. Procedures suitable for this packaging arrangement include all surgical operations, major diagnostic procedures such as endoscopies, and complex radiological procedures. The difference between this package and the physician DRG is that only those services directly and immediately related to the special procedure are packaged. For a coronary artery bypass graft, for example, the package would include services provided by the surgeon, assistant surgeon, anesthesiologist, and any other physicians involved in the operating room.

Conclusions

In sum, physician DRGs represent a Medicare payment reform aimed at controlling not only fees but also the number of services provided. The DRG payments themselves are best made to IPA-like organizations constituted by each hospital medical staff. In order to minimize selection bias and ensure equity for both beneficiaries and physicians, each staff would sign a Medicare Participation Agreement as a group.

STATEMENT OF RICHARD EGDAHL, M.D., DIRECTOR, BOSTON UNIVERSITY, HEALTH POLICY INSTITUTE, BOSTON, MA

Dr. EGDAHL. Senator Durenberger, Senator Dole, I appreciate the chance to testify before your committee. It is clear that some kind of reform in Medicare prevailing fees is needed, based upon the geographical variations and some excessive fees that have been described very adequately before various committees.

I do have some problems with some of the suggested changes. For example, as a practicing endocrine surgeon, I know that DREG's would have great financial risk, because the risk is not spread among enough cases. Also, I don't know how I would pay the other doctors because there is no coordinating mechanism.

As far as capitation is concerned, I disagree with the predictions of continued rapid growth. I belong to the two IPA's in my area, which are growing rapidly, and yet they provide a very small percentage of the surgical practice I have. Therefore, I do not agree that there will be very rapid rate of growth in capitation systems as predicted. Most of the growth that does occur will be largely in the fee-for-service sector.

The resource cost-based RVS, also has some basic problems from my perspective. The equations concentrate heavily on time; practicing physicians are not usually involved in the fundamental assumptions; they reflect a comparable worth approach for professionals with good incomes; but the most important factor is that the malpractice premiums are going up so high for some specialties important to elderly individuals—orthopedists, neurosurgeons, and the like—that I think all bets on manpower and accessibility are off for the short range; we just don't know what is going to happen.

Our Health Policy Institute has developed a consensus approach to help resolve some of the problems created by the way Medicare prevailing fees have been determined, which basically is initial charges, inflated yearly, without any judgment involved in changing those fees.

We convened a group of senior surgeons, had multiple iterations of independent judgment plus discussion, and finally came out with relative valves for 25 surgical services that they could agree upon and that represented a reform and a considerable change from what the prevailing fees were.

The problem with this approach is that it is cumbersome; As we began to work with surgical specialties and began to work with the internists, it became apparent that this was not a short fix; it would take 2, 3, or 4 years to really work through this kind of approach, gaining physician consensus which then would provide the basis for physicians accepting the kind of new schedule that would come out.

Therefore, looking around in the course of carrying out the study, we found a group that actually had done it. My basic message to you today is that fee reform, comparable to the consensus approach that we were looking for, has been achieved by the Caterpillar Tractor Co. of Peoria, IL. It is a completely self-funded corporation with over $6.5 billion in annual sales and over 71,000 individuals across the country covered by their health plan.

The key to this has been Dr. Robert Hertenstein, who is a 51-year-old retired surgeon, mayor of Morton, IL, who for 4 years has been the full-time medical director of insurance for Caterpillar. Dr. Hertenstein, who is with us today, has developed a maximum-fee schedule for most physician services. He has the goal—which is exactly the same goal that you seem to be talking about today—of insuring access to quality services for Caterpillar employees and their dependents across the country, with cost containment an important but secondary consideration.

I suggest that you look into the experiences of Caterpillar with physician fees, and see if it is readily adaptable to Medicare physician payments—and I predict that it is. The framework is already there, and various groups, I'm sure, including ours, would be pleased to work with you to catalyze the evolution of Caterpillar's experience into a reformed Medicare physician reimbursement system. This can provide a basis for reform, while the practicality capitation and the predictions about growth in capitation plans can be assessed.

My staff and I have had the occasion to spend several hours with Dr. Hertenstein, and have learned a great deal about how he has handled the conflicts that have arisen across the country, involving both medical and surgical specialties. Some of the principles he has employed I think would be of great interest to your committee.

Thank you.

Senator DURENBERGER. Thank you very much, Dick.

Dr. Stason.

[Dr. Egdahl's written testimony follows:]

Testimony of Richard H. Egdahl, M.D., Boston University

Health Subcommittee of Senate Finance Committee, U.S. Senate

December 6, 1985

SUMMARY STATEMENT

1. PHYSICIAN REIMBURSEMENT UNDER MEDICARE HAS TWO BASIC PROBLEMS THAT NEED REFORM:

   . Large geographical variations
   . Some excessive fees

2. OPTIONS FOR CHANGE INVOLVE MAJOR OBSTACLES

   Physician DRGs and CAPITATION

   . Financial risk from adverse selection
   . Coordination of many individual practitioners

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3. IF FEE-FOR-SERVICE IS TO BE CONTINUED

   Resource cost-based RVS is flawed

   . Problems with basic assumptions in equations (e.g. time as dominant factor)

   . Could decrease access by lowering fees in specialties with high risk of malpractice. Current predictions of manpower needs may be grossly incorrect.

4. A CONSENSUS METHOD TO ACHIEVE FAIR PHYSICIAN FEES was developed by the Boston University Health Policy Institute. Consensus was achieved in 25 commonly performed surgical procedures. The process is time-consuming and cumbersome.

5. AN EXAMPLE OF A MORE PRACTICAL ALTERNATIVE for physician fee reform has been achieved by a large self-funded American corporation--Caterpillar Tractor Co. in Peoria, Illinois. Dr. Robert Hertenstein, a Caterpillar employee, has developed a maximum fee schedule with the goal of achieving access for employees across the country to a wide range of local physicians.

GOOD MORNING. My name is Richard Egdahl. I am Director of the Boston University Medical Center. I am also Academic Vice President for Health Affairs at Boston University, Vice Chairman of the Board of Trustees of University Hospital, and Director of the Boston University Health Policy Institute. I am a practicing endocrine surgeon with a long-standing interest in cost-effectiveness and quality in medical practice. Thank you for the opportunity to testify on reforming Medicare payments to physicians.

INTRODUCTION

It has become increasingly apparent over several years that there are serious problems with the way Medicare pays physicians for their services. It is generally agreed that the customary, prevailing and reasonable (CPR) payment system currently being used by Medicare has resulted in wide geographic variation in fees for the same services and relatively excessive fees for some procedures (Table I). Concern over this issue has led to discussions about the possibility of introducing new methods of physician payment including capitation, DRG-based payment, and modification of the fee-for-service system. However, this interest emerges in an environment where little is known about the costs and benefits of different ways of compensating physicians for their services. Until recently, research has focused primarily on hospital expenditures which consume the largest portion of the health care dollar. Consequently, much less information is available on physician payment options compared to the volume of studies on hospital reimbursement when prospective payment was enacted.

Some insights about different payment models have been gained by looking at ways other countries have dealt with physician compensation. Uwe Reinhardt, in a recent report for HCFA, summarizes the advantages and disadvantages inherent in each of four distinct bases that can be used for physician compensation: fee-for-service, fee per case (MD DRG), capitation, and salary. He concluded that in the six countries studied (Canada, France, Italy, West Germany, United Kingdom, and the United States) no single method was obviously preferable to all others. Each has strengths and weaknesses.

TABLE I

MEDICARE PREVAILING CHARGES FOR SELECTED AREAS* (1984)

	DC	MD	MA	MN	NY
CABG (46)	3922.90	2940.70	3543.20	3665.10	5500.00
HIP REPLACE (47)	1547.10	2063.00	2358.00	2124.20	4126.00
CARDIAC CATH (51)	540.50	537.80	515.75	618.90	1196.70
PACEMAKER (52)	1428.40	1238.00	1237.80	1165.60	1547.00
APPENDECTOMY (54)	515.60	515.70	515.75	515.60	1134.70
CHOLE (57)	845.80	722.00	866.50	742.60	1753.60
EXT OF LENS (67)	1237.80	1031.70	1031.50	928.20	1547.25

* FEES INDICATED ARE FOR "SPECIALISTS" AND URBAN AREAS (IN DOLLARS).

U.S. Department of Health and Human Services, Health Care Financing Administration, Medicare Directory of Prevailing Charges 1984, Washington, DC: U.S. Government Printing Office, 1984.

Paying physicians by DRG raises the question of who to pay. Physicians in private practice are not experienced in directly paying their colleagues and consultants. Moreover, DRGs were designed using only hospital data, and their suitability for physician services is questionable. Generating a manageable number of physician DRGs that are sensitive to variations in case complexity would be most difficult. Both DRG-based physician payment and capitation pose problems of financial risk from adverse selection which has been a root cause for the failure of many health plans. This danger would be magnified many-fold in the case of individual physicians taking care of capitated patients.

Reforming physician payment within the fee-for-service system is not without problems, either. One prominent method that has been tried in Massachusetts uses "resource costs" to determine fees. This method attempts to identify all the components of medical practice and to estimate the costs associated with each of these elements. Every effort is made to quantify the unquantifiable. The resource cost-based model developed by Drs. Hsiao and Stason is the most elaborate effort of this type. My primary concern with this method involves the logic and assumptions underlying the resource cost-based equations. I disagree with the assumption of the appropriateness of all physicians having similar lifetime earnings, with modest corrections for time of training, skill, risk, and other variables. This formulaic approach is not unlike the "point-factor" job evaluation systems used by Willis Associates or Hay Associates for calculating comparable worth across occupations. However, a formulaic assessment process becomes progressively less valid as the ingredients of the "job" being evaluated are more complex and hard to measure, as is especially true in the practice of medicine.

Another important objection to the formulaic approach is not theoretical but practical. Current trends in malpractice premium increases, and the continually decreasing hours worked per week by new physicians result in a fundamental challenge to the attractiveness of some surgical and medical specialties and could lead to real shortages of physicians performing high risk procedures. The most current and frightening example is the increasing tendency of individuals with obstetric and gynecology training to either limit their practices to office gynecology, or to retire early in order not to deliver babies as obstetricians, which involves a high risk of malpractice. A recent article in the Wall Street Journal reported on a

study by the Florida Obstetric & Gynecologic Society that found that 25% of Florida's obstetricians have stopped practicing their specialty, and another 25% plan to stop. The primary reason is malpractice liability. Similar trends are being observed in orthopedics and neurosurgery. It would be most unwise at this time of flux, in the face of considerable uncertainty about future specialty manpower needs, to introduce a change that has the potential for grossly penalizing surgeons and internists who perform needed but high risk procedures.

Since there is considerable agreement that the present Medicare physician payment system is flawed, and, given the major problems with the options outlined above, what is needed is an interim reform that will correct discrepancies without major disruption in the organization of services, preserve access, and be viewed as fair. My testimony develops the theme that reform of Medicare fees can be obtained by building on currently available analyses and experiences to develop a maximum and fair fee schedule. First, I will describe the Massachusetts experience with changes in Medicaid fees in 1983 and 1984, which led to the involvement of the Boston University Health Policy Institute in developing a consensus method to achieve fair physician fees. I will then describe the method used in a large self-funded corporation, where reform in fees has been achieved by effective shortcuts to our labor-intensive consensus process. Finally, I will suggest that Congress authorize an appropriate reform of the current Medicare Part B program by following a process of rational fee development, building on the rich experiences of individuals in industry such as Dr. Robert Hertenstein, physician employee of Caterpillar Tractor Co. in Peoria, Illinois.

THE MASSACHUSETTS EXPERIENCE

In the fall of 1983, the Massachusetts Rate Setting Commission introduced a new fee schedule for Medicaid, based upon the "resource cost-based" model developed by Hsiao and Stason. Time needed to perform a service is a major determinant of the value of that service. Rates were increased for eight services including three categories of visits, and decreased for 20 procedures. Although individual physicians offered some input regarding the complexity of the services, estimates and assumptions about the relative importance of time, costs of training (including income foregone during training) and overhead expenses were developed by the researchers and provided the basis for the equations that resulted in these changed fees.

Experienced clinicians were at a loss to reconcile the new fee schedule with what they knew made sense regarding the relative complexity of services, when all aspects of the experience were taken into account. Surgeons in Massachusetts pointed out that the substantially decreased fee for an appendectomy as compared with that for herniorrhaphy (Table II) did not take into account the significant "down" time involved in making the preoperative diagnosis of appendicitis, in contrast with the rather routine elective situation that exists for a herniorrhaphy. By the summer of 1984, public

Table II

Changes in Medicaid Fees in Massachusetts
Fall 1983

Service	Old	New	Change (per cent)
Herniorrhaphy	$225	$154	-32
Appendectomy	$225	$136	-39

outcry by the physician population led to a rescinding of this new fee schedule and a restoration of the lowered fees to their initial level. The increased fees remained at their new, higher level.

The Massachusetts Medicaid program viewed the fee experiment as an attempt to improve access. They wished to promote participation in the program by increasing the rates for primary care services, relative to specialty services. The resource cost-based method was seen as a vehicle for achieving that end. One unanticipated outcome, however, was that by applying the model, many OB-GYN services had their fees decreased. Shortages of OB-GYN services have been, and continue to be, a problem for the Medicaid program in Massachusetts. Having fees in this specialty decreased could only exacerbate the problem. This situation points out the need for caution when "objectively" manipulating any fee system, particularly at a time when the organization and financing of health services are in a state of flux.

HEALTH POLICY INSTITUTE'S CONSENSUS APPROACH

As an expression of dissatisfaction with the formulaic approach to fee-setting, the Boston University Health Policy Institute convened a group of senior surgeons experienced in several different practice settings to devise a new consensus method for developing a complexity/severity index for physicians' services. Such an index would provide an appropriate basis for surgical fees. The results of these initial explorations were published in the spring of 1985. Using an open discussion preceded by exchanges of opinions on the relativity of various surgical services, agreement was reached on relative complexity and severity of 25 standard surgical services. This process appeared to permit reform of some excessive surgical fees. We proposed to extend this consensus process to surgical specialties and other fields of medicine. Our goal was to create a maximum fee schedule covering the majority of physician services paid for under Medicare Part B.

The essence of the consensus process was a give-and-take among experienced surgeons, involving an assessment of all the difficult-to-measure factors that go into a given service such as risk, complexity, severity of the case, necessary technical skills, etc. In contrast with a formulaic or Delphi method, the participants with strong opinions expressed them, but as discussion proceeded, compromises were made, and the surgeon most experienced in the procedure under discussion could exert influence upon the group. This is particularly important because a significant conceptual underpinning of many methods of obtaining consensus is the emphasis on lack of confrontation by individuals with differing personal intensities. This consensus method brought together experienced and respected surgeon panelists from a range of practice environments, and emphasized the sharing of their perspectives and impressions.

The process was designed to encourage the panelists to rate individual services based upon collective experience, rather than individual preferences. The rating of complexity and severity between meetings was done independently and anonymously to prevent individual panelists from exerting undue influence over the ratings. After three or four sessions, a consensus was reached, because the group had a common goal and works within a systematic process. However, this process, albeit professionally appealing and reasonable, was labor-intensive, time-consuming, and cumbersome.

A CORPORATE APPROACH TO DETERMINATION OF FEES

During the complexity-severity pilot project, the Health Policy Institute contacted many individuals across the country with experience in analyzing physician fees. We came across a person with much experience who had truncated our consensus process to reach the goal of a reformed and fair fee schedule that met the needs of his company and that apparently has been accepted by most physicians taking care of the company's employees around the country. Dr. Robert Hertenstein, a 51-year old surgeon, retired three years ago from active practice to work as an employee in the claims department of Caterpillar Tractor Co., a corporation in Peoria, Illinois with annual sales of 6 1/2 billion dollars and over 61,000 employees. He developed a maximum fee schedule for Caterpillar employees and their dependents across the country that involves the majority of "big ticket" items, and comes to grips with both the issues of geographic variations and excessive fees. In those specialties of medicine in which Dr. Hertenstein has not had personal experience, he consulted panels of experts who are widely respected by their peers. By cross-checking their fees with other respected specialists in their areas, he developed a fee schedule for Caterpillar that has been effectively applied. Unless the physician has made prior arrangements with the patient, Caterpillar holds the patient harmless for paying the physician more than the Caterpillar fee schedule, and the company position has usually been upheld in the courts.

Starting with maximum fee schedules developed by Caterpillar Tractor Co. and other private sector employers, and using physician expert consultants, a fee schedule could be rapidly developed for Medicare that will both

rationalize geographic differences and correct excessive fees in inpatient physician billings. The same process could be used to reform fees in outpatient settings, in which there is much greater variability. If the Congress were to mandate such a process, the two greatest objections to Medicare prevailing fees could be rectified--that of large and unexplainable geographic differences for given services and of excessive fees for some services.

I believe there would be considerable promise and applicability for the kind of system developed by Dr. Hertenstein for Caterpillar Tractor Co. It is a system which allows for the necessary flexibility required by regional differences, labor costs, etc. It is a system which will allow us to begin to develop a cost-effective but fair schedule for physician services. I suggest the Committee strongly consider the Caterpillar experience and others like it, in its efforts to come to grips with this problem. I am happy to offer my services and whatever expertise our Health Policy Institute can bring to the Committee and its staff or whatever agency you determine should further explore the subject.

Thank you again for this opportunity.

STATEMENT OF WILLIAM STASON, M.D., ASSOCIATE PROFESSOR OF HEALTH POLICY AND MANAGEMENT, HARVARD SCHOOL OF PUBLIC HEALTH, CAMBRIDGE, MA

Dr. STASON. Senator Durenberger, thank you very much for the opportunity to present my opinions to you here today.

I agree with many of the points made by my predecessors. Clearly, there is no one panacea for restructuring physician payments under Medicare.

The focus of my testimony today will be on the advantages of using an objectively determined relative-value scale for restructuring physician payment under Medicare. Although I will be talking primarily about fee-for-service, I also will argue that such a relative-value scale is equally important for reimbursement under capitation or the various packaging options.

There is widespread belief—and we have heard this expressed here today—that current physician charges favor technology-intensive procedures over cognitive and preventive medical ones. Distortions, we believe, result from the absence of a reasonably free market for physician services. This is due to a variety of factors which are well known to you: Widespread existence of insurance coverage, of which Medicare is an important part, the limited ability of the patient to determine the services he or she needs and to evaluate the skills of his physician, and the very real difficulty of shopping for the best buy when one is seriously ill.

Charge-based relative-value scales, such as the CPR formula and the multiple manifestations of the California relative-value scale, institutionalize and perpetuate distortions created by this absence of a free market.

For this reason, we have been interested in developing an objective relative-value scale to document any distortions and provide a basis for establishing a level ground for physician fees and balanced incentives, we hope, between technologically intensive procedures and so-called cognitive or preventive medical ones.

Our premise is that resource inputs are fundamental measures of value for medical services, as they are for many other products or services. Under this premise, Drs. Hsiao, Braun, and myself at the Harvard School of Public Health have developed what we call a resource-based relative-value scale. The primary emphasis in this model is on measuring the physician time required to perform a procedure, and also estimating the complexity of this procedure in terms of the clinical judgment, the technical skill, and the mental and physical effort requires on the part of the physician.

We also include practice overhead expenses, including malpractice premiums, and an estimate of the of the amortized costs of training.

We have intimately involved physicians in our work, and we believe that the expert judgments provided by physicians are crucial to developing a scale which will be valid and widely acceptable.

What we find from our studies is that there is considerable disparity between resource-based relative values and those determined from Medicare charges. Under charges, surgical procedures are paid at two to three times, and up to seven times, the rate relative to office visits, as indicated by the resource-based relative

values. Similar findings exist for diagnostic procedures such as colonoscopy and cardiac catheterization.

Admitting the preliminary nature of our results to date, we are nonetheless confident of our conclusion that significant price distortion does exist and that charge-based schedules are not optimal bases for reimbursement under Medicare.

An important feature of any relative-value scale is that it determines relative values and not prices. A conversion factor is used to convert or translate relative-value units to dollars. Policy objectives, then, can be met through manipulating the conversion factor—for example, to achieve cost control, a relatively restrictive conversion factor could be chosen.

In addition, it might be felt wise to reward the physician who has a demonstrably more severe case mix than other physicians, or to reward better clinical outcomes.

The advantage of the resource-based relative-value scale under fee-for-service reimbursement includes the following:

First, it will create incentives to increase the use of cognitive and preventive medical services and to decrease overuse of medical technologies. Also, it might well affect the specialty selections of medical school graduates in favor of primary-care specialties, over the relatively overpopulated technologically intensive specialties.

Second, it is relatively easy to implement, in that the mechanisms for fee-for-service reimbursement already exist. Furthermore, it would relieve the administrative burden of having to update physician profiles on a regular basis which is required the CPR formula.

Third, it would continue fee-for-service as one option available to Medicare recipients. Medicare recipients should have the same freedom of choice of insurance plan that is accorded to other members of society. This is a fundamental equity issue, in my view.

Limitations of the resource-based relative value scale approach need to be ackowledged, however. Two to three years will be needed to develop a sound resource-based relative-value scale.

Second, no relative value scale guide, fee-for-service mechanism will directly control utilization. However, if the RVS were linked to a regional cap on physicians' expenditures, it could do so.

The need for an objective relative-value scale extends fully as much to the capitation and packaging options, and to HMO's, PPO's, IPA's, as it does to fee-for-service reimbursement. Under capitation, a resource-based relative value scale would help us to determine the physician component of the capitation rate. While providing incentives for reduced use of costly technologies and hospital services.

Under packaging, it would provide an objective basis to set rates. Current charges are not adequate measures. Under HMO's, it would help to establish physician salaries in relation to specialty and work schedules.

In conclusion, we believe that development of an objective relative-value scale is one important step to ensure a smooth transition to whatever method(s) of physician reimbursement are chosen. The method you choose for paying physicians under Medicare is going to have very important implications for access to care and the qual-

ity of services provided to Medicare recipients. Carefully conceived incremental changes are the prudent course, I believe.

Thank you very much.

Senator DURENBERGER. Dr. Wallack.

And let me just remind you that Dr. Stason used up Dick Egdahl's extra minute, so you don't have it.

Dr. WALLACK. Well, I think I am probably the only one that originally came from Boston, and I talk very fast. [Laughter.]

[Dr. Stason's written testimony follows:]

Physician Reimbursement: The Role of Relative Value Scales

William B. Stason, M.D., M.S.

Associate Professor, Health Policy and Management

Harvard School of Public Health

Testimony Given to the Subcommittee on Health

of the U.S. Senate Finance Committee

on

December 6, 1985

Summary

Distortions exist in current charge-based physician reimbursement formulas which favor technologically intensive procedures over cognitive or preventive medical services. Under charges procedures appear to be reimbursed at a minimum of 2 to 3 times the levels suggested by a resource-based relative value approach. Physician reimbursement under continuation of Medicare's current CPR formula or under a charge-based RVS would perpetuate these distortions. An objective relative value scale (RVS) would provide "level ground" for physician fees and would help to balance incentives for the use of different types of services.

Our work on resource-based relative value scales suggests that this approach could provide a rational basis for altering financial incentives in the medical marketplace. Cost control could be achieved either by selecting a restrictive of the conversion factor for translating relative values to dollars or through regional physician expenditure caps.

Adoption of an objectively-determined RVS would be useful not only under fee-for-service reimbursement, but also would important contribution to setting rates under capitation or other packaging options.

- Text -

Debate on physician reimbursement under Medicare concerns both the need to control the rising costs of physician services and the

need to select a method of payment that will best protect Medicare recipients' access to needed medical services. Policy options to achieve these ends include modifications to the current CPR system for setting fee-for-service reimbursement levels, payments based on packaging services or episodes of illness, and capitation. Each method has its own strengths and limitations; no one is a panacea; and each will impose significant challenges to development and implementation.

My testimony today will focus on a fundamental building block for restructuring physician payments; namely, on the advantages of using an objective relative value scale (RVS) to guide physician reimbursement. Though I will be speaking primarily about fee-for-service reimbursement, I will also argue that such a RVS would provide a critical input to reimbursement methods based on capitation to the packaging of physician services.

Current charge-based relative value schedules for physician services favor technologically intensive services over cognitive or preventive ones. Economists argue that these "price distortions" result from the absence of a reasonably competitive market for physician services. Many factors contribute to this situation. Widespread insurance coverage, of which Medicare is an important part, is one of these. Another is the fact that patients usually lack adequate knowledge to judge their needs for medical services or to evaluate the technical skills of their physicians.

Furthermore, an individual whose medical condition is urgent or life-threatening is hardly in a position to shop for the "best buy." Price competition for physician services is, and will continue in the future, to be limited.

In the absence of a free market for physician services, charges well may not provide socially desirable guides to physician reimbursement. Charge-based RVS's such as Medicare's CPR formula or the widely pervasive California Relative Value Scale (CRVS) institutionalize and perpetuate any distortions that exist. On the other hand, an objective RVS could provide a "level ground" for physician fees and help to create incentives for the appropriate use of primary care and preventive services as well as technologically intensive ones.

To explore possibilities for correcting charge-based relative value schedules, we (Hsaio, W., Braun, P., Stason, W.) have developed a method to measure the resource inputs required to perform physician services. We call this a Resource-Based Relative Value Scale (RBVS). Our premis is that resource inputs into physician services provide the fundamental measure of their values. Primary emphasis in our model is to measure the physician time required to perform the service and the complexity of the service, as determined by the degree of clinical judgement, technical skills, and physical and mental effort required. In addition, practice overhead costs, including malpractice premiums,

and the amortized opportunity costs of the additional training required for some medical specialties are included. Significant disparity exists when RBRVS values are compared to current medical charges. Table 1 shows examples for selected surgical subspecialties. Our basic finding is that the values of surgical procedures relative to office visits are, at a minimum, 2 to 3 times higher when calculated on the basis of charges than when calculated from resource inputs. We also found similar disparities for diagnostic procedures such as colonoscopy and bronchoscopy.

Even admitting the preliminary nature of our results, we are confident of the general conclusion that significant physician price distortion does exist in the favor of procedure-oriented medical practices. This distortion argues strongly against continuation of the CPR formula and against use of a charge-based RVS under any method for reimbursing physicians.

Our current resource-based model should be refined to include the effects of practice setting on overhead expenses and the effects of substituting the time of technicians or other health professionals for physician time in surgical or diagnostic procedures as well as office practices.

In addition, many argue that the expected health benefits of a given service should be taken into account. For example,

coronary bypass surgery in a patient with severe angina and three vessel disease might deserve a premium over the same type of surgery in a patient with one vessel disease and mild angina because of the stronger evidence that surgery is the treatment of choice and because benefits in terms of prolongation of life and relief of morbidity are likely to be greater. Valuation of health benefits, however, is a complex matter, and techniques for measuring effects of medical care on the quality of life are still in their infancy. The subject is of considerable importance to decisions on the allocation of resources within medical care, however, and should, in my view, be a high priority for future research.

An important feature of all RVS's is that they determine the value of one medical service relative to another, but do not directly set prices. A conversion factor is used to translate relative value units into dollars. Clinical decisions on relative values are thereby made distinct from policy-relevant decisions. A variety policy objectives can be met through the selection of the conversion factor. Cost control is one such objective. Varying the conversion factor to reward physicians with demonstrably more severe case-mixes or those who achieve better clinical outcomes are other possible objectives.

Development of a RBRVS should intimately involve physicians in the selection of procedures and other services that typify

each specialty and to ensure that the values derived accurately reflect key variables such as the technical skills, clinical judgement, effort, and time required to perform a procedure. The relative values derived need to appear reasonable to physicians, if they are to provide an acceptable standard for reimbursement.

The advantages of a RBRVS under the fee-for-service method of reimbursing physicians are several. First, as state previously, such a scale would help greatly to "level the ground" of physician fees and create balanced incentives for the use of technologically intensive procedures and primary care and preventive medical services. A resource-based RVS also might well curb the current tendency toward overuse of medical technologies. Second, a resource-based RVS, in many ways, might be the easiest reimbursement method to implement. The mechanism is already in place to pay physicians by fee-for-service, and use of an RVS would remove administrative burden of continuously updating physician profiles as is done under the CPR method. Third, continuation of the fee-for-service option under a RVS, perhaps as one of several options, will allow Medicare recipients the same freedom of choice of payment method as exists for other members of society. This, in my opinion, is a significant equity issue.

Limitations of a RBRVS also need to be acknowledged. There is no question that it will take time to develop a RBRVS that will stand the test of scrutiny both by the medical profession and

by society. Two years is a reasonable estimate. Temporizing changes in the CPR formula could be used to control costs in the meantime, if this were deemed necessary. A second limitation is that, fee-for-service payment under a RBRVS does not directly control utilization. Selection of a restrictive dollar conversion factor would be one way to control costs. Alternatively, payment by RVS could be coupled with a regional cap on physician expenditures. This would act, in some respects, like a capitation fee but at a regional, rather than on individual patients, level and only for the physician component of medical costs. If properly conceived, such a cap could serve as an incentive to physicians to limit marginally necessary medical services, and hence be cost-effective, as well as being an effective way to control costs.

The need for a RBRVS is not limited to the fee-for-service system of reimbursement. Our RBRVS could also make an important contribution to other methods of reimbursement, including capitation. One of the major challenges to the capitation method is to determine of appropriate capitation rates. This challenge is particularly difficult in the elderly whose needs for medical services is both high and highly variable from one individual to another. Use of an RBRVS could have a favorable effect on capitation rates both in terms of the physician fee component itself and in terms of the incentives it might create for decreased use of costly hospital services.

An RBRVS could also make important contributions to the various packaging options, including physician DRG's, and to HMO's, PPO's, and IPA's. For the packaging options, an RBRVS would provide an objective basis for setting rates; for HMO's it would facilitate establishment of physician salaries and work schedules; and for PPO's and IPA's in would provide an objective basis for setting relative reimbursement rates for the physicians who participate in these organizations.

Finally, creation of an RBRVS would be an important building-block in insuring a smooth transition from fee-for-service to other methods of reimbursement, if these were deemed preferable for the Medicare program. The method chosen for physician reimbursement will have important implications for access and the quality of services available to Medicare recipients. Prudence dictates that we move carefully, and incrementally, toward an improved system for phyrician reimbursement.

Table 1

Comparison of Relative Values Calculated from 1983 Medicare Charges and Estimates from Resource Inputs

	Charge-Based		Resource-Based	
	Charges	Ratio	Value	Ratio
General Surgery				
Initial Complete Office Visit	$ 52	1.0	0.4	1.0
Initial Intermediate Hospital Visit	100	1.9	-	-
Appendectomy	550	10.6	1.0	2.5
Total Abdominal Hysterectomy	1,100	21.2	2.1	5.3
Cardiovascular Surgery				
	Charges	Ratio	Value	Ratio
Initial Complete Office Visit	$ 80	1.0	0.5	1.0
Initial Intermediate Hospital Visit	110	1.4	-	-
Insertion of Pacemaker	1,060	13.3	1.6	3.2
Coronary Artery Bypass	3,000	37.5	7.5	15.0
Ophthalmology				
	Charges	Ratio	Value	Ratio
Initial Comprehensive Eye Exam	50	1.0	0.5	1.0
Simple Extraction of Lens	1,100	22.0	1.5	3.0

STATEMENT OF STANLEY S. WALLACK, PH.D., DIRECTOR, HEALTH POLICY CENTER, HELLER GRADUATE SCHOOL, BRANDEIS UNIVERSITY, WALTHAM, MA

Dr. WALLACK. I appreciate the opportunity, Senator Durenberger and Senator Heinz, to speak. I would like to emphasize two points today.

First, I think physician capitation is the preferred option in dealing with the physician-related problems of today and the physician marketplace of the future; but it is a very limited option, as we currently conceive the traditional HMO.

The second point is that a physician capitation option, where you would capitate only for part B services, has a lot of advantages over traditional HMO's. First, you could have capitated plans in a lot more areas of the country, particularly rural areas; second, the Federal Government or the insuror would directly receive some of the savings from the reductions in hospitalizations, which now go to the traditional, HMO plan. Third, under a partial capitation model, or what I call a physician plan, you don't put the beneficiary under the threat of a reduction in the quality of care occurring in the future. And finally, from a long-run-care policy perspective, the partial capitation the program provides a better balance between the managers of the Medicare Program, and providers, because you would share not only the risks with these plans but also the policy control. I want to emphasize the last point.

The current HMO is too much like a black box for payers. You don't know what is going on inside them. With shared policy or shared risk arrangements, you would have a lot more control over what is going to happen in capitated plans in the future.

The first point is why physician capitation makes sense. We have heard today about the physician expenditure problem—intensity and higher volume. These issues are addressed with a capitated approach since physicians have to deliver all the care for an individual efficiently.

Another advantage of a physician capitation approach is that it forces providers to plan care for the enrolled population. As a result, you find much less variation in utilization rates across the country in HMO's, than in the fee-for-service system. We have, for example a large variation between hospital days in Boston and California with fee for service whereas in HMO's in these communities, variation is very minimal. HMO's, prepaid plans, or managed plans by their very nature have to deal with treatment protocols.

The third reason why a physician capitation model is more desirable—is that you can take advantage of the increased supply of physicians, and in the future cost of physician care. If you move to a ratesetting model, what are you going to do? You are going to freeze in the existing system and rates, and you are going to have to regulate them.

The final reason for wanting a capitated system is that it means less administrative burden and cost at the Federal Government level. All the other models you have heard about today lead to a lot

of intervention and a lot of administration. A capitated system would not.

However, traditional capitated models are very limited in design and there are some real problems with the current HMO's. The physician capitation models, or partial capitation models, as I call them, offer some alternatives or ways to improve on the existing HMO models.

First, is the issue of price. The issue of prospective price it is saying to the provider: "Be efficient." Now, you can go too far with the prospective price, to the point of reducing quality; and that is an issue we will have to address.

The second element of the capitation payment is insurance. You are saying, basically, "Care for the population," and you set up underwriting factors as if they were caring for the whole population. It is very likely that the Medicare HMO Program, is not caring for a representative population because it is a voluntary program for providers and beneficiaries. The HMO enrollment, whether paid for by private sector or the Medicare Program, does not have a representative population. We have heard that today from the AARP representatives. Because HMO's have relatively fewer sick individuals, and more is being paid out under this insurance underwriting program than under a fee-for-service environment. If we evaluated the cost-effectiveness of existing TEFRA Program, we find we are losing money as the numbers enrolled grows. That is, we would be saving only 5 percent if HMO's enrolled a representative population. However, since they enroll a healthier population, total program costs are probably higher.

What HCFA needs to do under a voluntary capitation program, is to take on more of the insurance or risk. In a compulsory program, like the DRG Program, you wouldn't worry from a budget perspective about the adverse and the favorable selection; everybody would be included. But under a voluntary program, it is a real concern to have the Government give up the insurance function.

I think we need to move forward in building upon the strategy of capitation. Besides, that is how I arrived at partial capitation. What I really have in mind is the Federal Government maintaining some insurance role in a voluntary system.

The other major problem is our traditional idea of an HMO. This needs to change. There are other ways to conceive of capitations; one that would allow the Federal Government to get the savings. For example, with a physician capitation model there is a real potential of HFCA receiving the savings from reduced hospitalization.

In the average HMO plan today, the plan derives the benefits. If you were to start to capitate for physician services, the savings would occur and you would share in them.

Let me now discuss with you two models that exist—I've talked about physician capitation in theory, but there are two models that Congress could adopt.

The first is the physician plan, where you capitate a group or plan for part B services. They would then have some incentive or some bonus arrangement with regard to reductions in hospitalization. This model is being used all around the country in the private sector. There are Blue Cross plans in Illinois, Colorado, and Massa-

chusetts that are doing exactly this. They are going to the physician group and capitating them, asking them to operate as the gatekeeper, and asking them to manage the system. The insurers are getting some of the benefits from that reduced hospitalization.

Thus, eliminate the middleman and deal directly with the supplier. If you want to get savings from the HMO strategy, the alternative is the physician group model.

The other model is the geographic model. The geographic model would include all beneficiaries who reside in the community and decide to stay on in the fee-for-service plan. All those in other competitive plans—the traditional HMO's, and the physician plans—would be outside of the geographic area. You could set this up with an insurance carrier or another party that is able to efficiently manage care and pay bills.

Under part B of the plan, you could use, for example, the current 41 carriers that cover the United States. In fact, you could create a national plan with these carriers and have them take a capitation arrangement for all the part B services and as a prospective price on budget, they would have an incentive to manage the physician market place efficiently. This model, again, is not imagined by me; it has actually existed to some extent in Texas since the beginning of Medicaid.

The State of Texas has acted as an insuror and hires an insuree to manage their whole State's Acute Care Medicaid Program on a fee-for-service basis. The State maintains the policy control, they pay a capitated rate, and the insuror is asked to manage the system.

I have had the opportunity to evaluate that program and have found the insurer to be very successful in controlling utilization. The incentives of the system are very interesting and relevant to the idea of sharing risks—Texas sets a per capita premium based on what they think the cost is going to be; they give the carrier an administrative rate, and they then set a risk corridor. In Texas today the risk corridor is 9 percent. If the carrier goes below the premium by running a more efficient program, the State gets 85 percent of the savings and the plan gets 15 percent of the savings.

That plan, as I said before, has been effective in reducing utilization in the system.

What is also interesting about that plan is that it has been stable for the last 20 years. It has been in existence since 1965. I believe one of the reasons it is stable, Senators, is because the savings that result are shared by the State. I must say, wouldn't it be unique if the Federal Government ran a program whereby they could actually show savings? So often, when you establish your cost-containment programs, the savings are invisible. These would in fact be visible savings. Because they are visible savings, and you are able to monitor whether or not it is an efficient plan. I believe in the long run a program like this would be more stable from abrupt changes in policy.

[Dr. Wallack's written testimony follows:]

TESTIMONY

to the

Senate Committee on Finance's

Subcommittee on Health

CAPITATING PHYSICIAN SERVICES UNDER MEDICARE

by

Stanley S. Wallack

Dirksen Senate Office Building
Washington, DC
Friday, December 6, 1985

I am Stanley Wallack, Director of the Health Policy Center at Brandeis University. I appreciate the opportunity to testify before the Subcommittee on Health on physician payment reform. My major objectives today are to identify the alternative physician capitation approaches that the Federal government could adopt, and to describe their likely performance. However, before doing that, I will discuss two points that logically precede a discussion on the capitation alternatives.

First, capitation appears to be the physician payment reform best suited to deal with the health care problems and environment of the future. Second, viable physician capitation programs can vary widely in design features. In deciding which capitation program(s) to pursue, the Federal government must decide whether it wants to maintain control over key policy parameters. If the Federal government wants to have policy control over important issues such as provider participation and payment rates (ones over which it has no control with traditional HMO plans), it must accept more of the financial risk. However, despite this, risk-sharing or partial capitation systems, e.g. physician capitation, may provide a more desirable long-run outcome. By reducing the risk to providers and the incentive to underserve, a partially capitated system could yield greater savings to the Federal government and not place the quality of health care in jeopardy.

Designing a Physician Payment Plan that Fits the Future

As this Subcommittee knows all too well, physician expenditures increased more than fourfold, from $1.8 billion to $7.8 billion, between fiscal years 1970 and 1980. Efforts to control the rates of increase began, including the fee freeze incorporated into the Deficient Reduction Act of 1984. Physician expenditures, under Medicare, however, are still expected to nearly double between fiscal years 1980 and 1985.

These higher expenditures will be increasingly attributed to the greater intensity or to the quantity of physician services. The intensity takes various forms, e.g. more surgeries, more consultation per hospital stay, and longer visits. Higher physician costs per visit have been attributed to unpackaging (billing for the various components of a visit) and procedure inflation (billing the same services under a more complex, expensive procedure.) Insurance protection plus the inability of consumers to control the content of a physician visit have facilitated this rise in intensity. With physician fee freezes and the reductions in the hospital length of stay, physicians might respond by giving more care per visit or by increasing the number of visits. The possibility of increased physician services in the future is compounded by the rapidly expanding physician supply.

It is difficult to control the increase of physician services because the appropriateness and/or necessity of care is often a question of medical judgment. Because much of medicine remains an art, a variety of acceptable medical ways to treat patients and problems are diagnosed differently by competent physicians. The result is widely varying Medicare expenditures per beneficiary within and across geographic areas.

Any new physician payment system must address the "quantity" issue, recognize the variation in physician practice patterns, and leverage the increased supply of physicians. It also must be amenable to emerging major cost containment strategies.

Figure 1 provides a framework for assessing alternative physician reform strategies along two key dimensions: the unit of service and the price setting mechanism. As one moves down the column under Unit of

FIGURE 1

Unit of Service \ Price Setting Mechanism	Provider Determined	Competitive Bidding	Negotiated	Rates Set by Payers
Procedure	current system	0	X	X
Procedure package	X	0	?	X
- surgical				
- diagnostic				
Admission or per case	?	0	0	X
Episode	?	0	0	X
Capitation	X	X	X	X

X = feasible change

0 = not feasible change

? = questionable change

Service, increased "packaging" of physician services occurs, from the current set of procedures to capitation. The higher the level of "packaging" the better addressed is the quantity dimension. Across the top of Figure 1 are the different ways physician prices could be established in the market; the four approaches (provider determined, competitive bidding, negotiation, and rate setting by payer) exhaust the alternatives. In a market of increasing supply, rate setting could lead to higher than necessary physician payments.

In Figure 1 I have identified the current physician system (procedure, provider determined) and the alternatives most feasible with an "x". As shown in Figure 1, I believe all the reform in physician payment system rates will be likely payer determined, i.e. regulated rates, except those that emerge under capitation.

Capitation is also to be the preferred unit of payment for achieving cost effective care. Payers are adopting two basic strategies in an effort to assure an efficient health care system. First, they are seeking to make beneficiaries and providers more cost-conscious by instituting cost-sharing. For the beneficiary, this means copayments. For the provider, prospective prices entail cost sharing, since with fixed prices higher costs will yield lower net incomes.

The other cost containment efforts can be grouped under the heading of managed care. Here, I am thinking of efforts such as prior authorization for admission to a hospital, medical protocols, and programs that utilize more efficient providers. Managed care efforts may, at times, complement prospective fee-for-service pricing. For example, under the DRG payment system, both hospitals and payers want to encourage early discharge to home

care. In other instances, they may be in conflict. A short admission may be more attractive to a hospital provider than caring for the individual on an outpatient basis, but more expensive to the payer. Also, if home care agencies were paid a flat rate, would they be willing to take sicker patients? If Medicare adopts prospective pricing for all major services, it must recognize the need for greater patient management and control at the interface of the different providers.

Capitation is the most attractive prospective unit of payment because the incentive to manage care efficiently is incorporated into the payment. The incentive under capitation is to provide all care efficiently, to provide the care in the least costly setting, and to provide less, rather than more care.

Medicare has recognized the advantages of capitation and, recently encouraged Medicare beneficiaries to join HMOs, in turn, Medicare has encouraged HMOs to serve the beneficiaries under the TEFRA legislation. HMOs can be expected to reduce total hospital utililzation of Medicare beneficiaries. Moreover, the geographic differences in hospital use rates are likely to be much closer in HMOs than in the fee-for-service markets. Early evidence of this appeared in the Medicare HMO at-risk demonstration. Two of the participating plans were the Kaiser Plan in Portland Oregon, and the Fallon Community Health Plan in Worcester, Massachusetts. Days of hospital care per 1000 in 1983 were 1800 and 2000 respectively, while the community rates under fee-for-service were 2900 and 4400 respectively.

I believe it is reasonable to enact a national capitation payment system for physician services only since the number of Medicare beneficiaries joining full-service HMOs is not likely to exceed a few million in the next several years. These capitated programs, (full-service

and physician), could exist side-by-side in the community. However, national physician capitation systems would provide the incentive to control the rate of hospitalization throughout the country.

Physician capitation systems have three key advantages over full-service capitation programs. First, a physician capitation program requires a smaller enrollment to break even. This allows plans to prosper in rural areas, small towns, and other less densely populated areas. Secondly, Medicare would benefit financially from the reductions in hospitalization. With traditional HMOs, most of the savings accrue to the HMOs. Finally, physician capitation programs are less likely to lead to underservice, since providers would not be at full risk for expensive care.

In summary, physician capitation programs could co-exist with traditional HMOs and do not need to replace them. As we take steps to expand capitation, it seems sensible to explore alternatives, particularly ones that might result in a more preferred outcome in terms of the balance between the cost and quality of health care.

Alternative Capitation Designs

In designing physician capitation systems, it is important to stress what capitation is and is not. Let me begin with the definition of capitation:

> **Capitation is a fixed per capita payment for a defined set of benefits for a fixed period of time.**

Using this definition, we can see that an entity receiving the payment for physician services need not be a provider and need not be at total risk or reward for the differences between payments and costs.

A capitation payment incorporates two features: prospectivity to insure

efficient production and insurance or averaging to cover the variation in costs. Traditional HMOs have merged insurance and delivery. This, however, need not hold for the future. Capitation pricing encourages the entity receiving the payment to deliver care efficiently, and to manage, plan, and budget the included services on a population basis. In addition to delivering care, the capitated entity assumes the insurance functions. Over the past few years, insurers have learned to manage care. Thus, we now have capitated systems in which an insurer receives the payment and manages the care.

Because traditional capitation programs place the entity receiving the payment at full risk, the establishment of a right or fair price is crucial to the success of a capitation program. Also, prospective prices in general, whether fee-for-service or capitation, have a significant built-in incentive to underserve, since any reduction in costs yields higher profits. The current concern with early discharges under the DRG hospital payment system illustrates this problem.

As we explore capitation options, we need to consider how they impact on our ability to: 1) establish a "fair" per capita price and 2) minimize the incentives to underserve.

A "fair" price for the capitated entity and the payer would be one that protected both parties from adverse or favorable selection and from the "luck of the draw". These are serious problems under a capitation payment system since the use of services among the elderly is highly skewed. For Medicare, it has been shown that only 5 percent of the enrollees account for over half the expenditures, and that the standard deviation of expenditures is almost 3 times the mean.

A payment system based on voluntary enrollment must try to incorporate these large variations in expenditures to protect the payer and provider from selection bias and the risk of enrolling a disproportionate number of high-cost individuals. Also, a plan can protect itself from such risk through higher numbers. The current AAPCC offers little protection. It has been shown that the inclusion of health status as a variable in the capitation or AAPCC payment formula would reduce the risk. Finally, some sharing of the risk between the government and the plan could prevent financial catastrophe. If this risk-sharing takes the form of partial capitation as would be the case with a physician capitation system, the incentive to underserve would be reduced.

In addition to deciding with whom to share and how much risk should be shared, Medicare needs to determine what its role will be in determining eligibility, provider participation or exclusion, coverage and monitoring for quality and access. Many of these policies are relinquished with traditional HMOs. These plans can restrict the number of providers or exclude particular providers, and they can establish criteria for receipt of services as well as method of service delivery. Medicare need not relinquish as much control over policies to capitated plans, but in maintaining more controls, Medicare must be prepared to assume more of the risk and cost.

The previous discussion defined the major issues that must be addressed by payers in constructing a capitation program for physician services or, preferably, all Part B services. Two payment alternatives emerge. In the first, the capitated payment could go to either a provider or insurer for their enrolled beneficiaries. A second option is to have the program receive a per capita payment for all residents in the geographic area that

are not enrolled in a prepaid health plan. Under the latter option, individuals still receiving their care on a fee-for-service basis would continue doing so, but the capitated entity would have an incentive to administer the program efficiently and manage the care of the beneficiaries.

These two alternatives are possible and perhaps more desirable than existing capitation arrangements, but they are not prevalent. Their limited presence can be attributed to the minimal experience of most large payers with capitation. Also, if HMOs achieve their savings and net income from reduced hospitalization, it is unlikely that they would propose physician capitation systems. Not surprisingly, therefore, the innovative arrangements described below were initiated by Medicaid programs.

The Physician Capitation Alternative

A. Voluntary Enrollment in The Health Plan/Physician Group Capitation

To a limited extent, we already have health plan capitation as a result of TEFRA. As specified in the final regulations, HMOs and Competitive Medical Plans (CMPs) can receive 95 percent of the AAPCC for Medicare enrollees, subject to the provisions of the law and regulations. Although many HMOs are responding favorably, moving to a national capitation program via this route may be very slow since HMOs still have less than 8 percent of the total U.S. market.

To more rapidly implement a plan based capitation system, Medicare could develop a capitation option for Part B services and include bonuses/penalties for hospital utilization rates or expenditures that vary from target levels. Since these capitated plans would entail less risk and smaller capital outlays, the number of participating plans could significantly increase.

The participating plans would be paid 100 percent of the AAPCC for Part B services for each Medicare enrollee. This would be payment for all Part B services and for total management of cases, including hospital admissions, treatment and discharges. The costs of physician services, referrals and outpatient tests would be assumed by the plan. HCFA would pay all Part A treatment costs for those plan members properly referred. Under such a system, beneficiary care would be managed, potentially improving continuity of care, dollars would be saved without reducing the quality of care or increasing beneficiary liability. The power of this approach is derived from the physician's role as the gate-keeper to specialists and hospital care.

If the bonus/penalty system for hospitalization is dramatic enough and the Part B AAPCC payment covers the provision of outpatient hospital services, Medicare hospital expenditures should be reduced. Furthermore, much of the hospital savings would accrue directly to HCFA. That is, unlike HMOs where the savings on hospital care accrue to the HMO, capitation for Part B only would allow HCFA to retain most of the savings.

A potential shortcoming of the physician plan capitation alternative is that it establishes incentives to underprovide, such as for referrals to other physicians. Also, for small group practices, the personal financial consequences to the physician of underproviding are stronger and more direct. Unlike HMOs and CMPs, most group practices do not have organizational mechanisms in place to monitor a colleague's behavior. Monitoring access and quality, therefore, will be a critical federal responsibility, which could be an expensive undertaking.

Medicare could gain insight into this option by evaluating the success or failure that states have had with such systems, often referred to as

primary care networks. The program in Wayne County, Michigan, termed the Capitated Ambulatory Plan (CAP), closely resembles the Part B capitation option described above.

1. Michigan's CAP Program

During the past dozen years, the Michigan Medicaid program has been developing alternative delivery systems. Currently, over 40 percent of the Medicaid eligibles in Wayne County, Michigan are enrolled in alternatives to fee-for-service. In addition to the CAP program, individuals can opt for a Primary Care Sponsor Program (physicians are paid a fee for managing all the recipient's care) or an HMO. The CAP option is available to practices that serve between 50 and 5,000 Medicaid clients.

The CAP receives a capitation payment for Medicaid services other than inpatient hospital services. Hospitals are paid directly by the state at the standard rates. The capitation payment was set, at least initially, at 100 percent of the community fee-for-service rate. Savings from reduced hospital use are to be shared equally, but the CAP plan's share cannot exceed 10 percent of the total capitation amount. The experience to date with the CAP program is too limited to provide a full understanding of its potential.

The small number of providers participating in the CAP program suggests that those providers who are able to go at risk may prefer to establish an HMO since they receive the net income from reduced hospitalization. While we do not see payers establishing pysician capitation models, it is worth noting that private insurance companies and HMO providers have established networks of physician groups as the cornerstone (case managers) of their capitated delivery systems. Often, these groups receive a per capita payment for physician services.

The success of the group network HMO model suggests that CAP-like systems have promise and could develop alongside TEFRA authorized HMOs and CMPs. But the likely preference for larger provider groups to assume full-risk as well as the time it will take to develop eligible plans, indicates that this model cannot become the national physician payment program in the near future. It could, however, become popular with physicians over the next few years if fees are kept under tight restraint.

B. Carrier Groups Capitation: The Geographic Alternative

In contrast with the group practice/health plan alternative, capitating carriers for Part B services could be implemented nationally. Currently, there are 41 private insurance carriers who use 225 geographic areas or localities for establishing physician payments. These localities (or states) could be used, and the current carriers given the first opportunity to participate under a limited risk-sharing arrangement. A carrier-at-risk system would provide a long-term strategy for containing Medicare's fee-for-service costs and could co-exist with local capitated plans, whether they be for Part B or for all Medicare covered services.

While there are two long-running intermediary-at-risk Medicaid programs in existence, the Texas Purchased Health Program and the Redwood Health Foundation in California, there are no programs limited to physician services. Before describing the features of a carrier-at-risk system, it is helpful to briefly review the experience of these two programs.

1. Texas' Purchased Health Services Program

The Texas carrier capitation program has been in operation since the inception of the Texas Medicaid program in 1967. Currently, Texas' Department of Human Services contracts with National Heritage Insurance Company (NHIC), a wholly-owned subsidiary of Electronic Data Services (EDS)

to provide acute care services. A six year contract was awarded in March, 1983, with rate negotiations to occur annually. NHIC has been the Medicaid contractor since 1977, succeeding Blue Cross. NHIC receives a premium payment per eligible person each month, based on two categories: AFDC and Aged, Blind, and Disabled. The premium payment includes two components:

- o pure premium, based on actuarial experience
- o administrative charges, which are currently equal to 5 percent of the pure premium.

The pure premium payment applies to all acute services, (laboratory, radiology, physician, pediatric, optometric, ambulance and home health care services). Long-term care, prescription drugs, and a few other minor services are not included.

The State agency retains policy responsibility for establishing eligibility and payment to providers. NHIC must pay providers according to Medicare principles of reimbursement, a generous payment relative to many other Medicaid programs. All physicians and hospitals that are certified by Medicare may be Medicaid providers, as long as they agree to accept assignment and comply with program requirements regarding medical necessity reviews, retrospective auditing and recoupment.

In the 1983 contract, the State of Texas altered the risk- sharing arrangement because the substantial profits made by NHIC under its 1977 contract were a source of contention. In the current contract, a "quota share" insurance arrangement exists within a risk corridor. There is a 9 percent risk corridor surrounding the pure premium, with NHIC at risk for 15 percent and the state for 85 percent. Losses and gains are shared in these proportions, making the maximum profit or loss for NHIC 1.35 percent (9% of 15%). The state assumes all risk beyond the 9 percent corridor.

Because the state assumes the bulk of the risk, there is no longer a risk premium paid to NHIC.

Even with the limited risk, NHIC has a strong incentive to contain per capita expenses below the pure premium amount. A 1.35 percent maximum profit or loss amounts to about $7 million on a $500 million dollar Texas program. Because the fee-for-service payment rates are set by state policy, NHIC must concentrate its cost cutting activities on the volume of services. While the medical necessity review techniques pursued by NHIC may not be "state of the art" or all encompassing, NHIC has been a pioneer in these areas and has implemented its reviews aggressively. Through a reasoned, consistent approach, there is evidence that the program altered the practice behavior of physicians treating Medicaid beneficiaries.

Despite this level of monitoring, however, there has been a substantial increase in total expenditures and a shift in the types of services provided to recipients. The higher Medicaid expenditures can be attributed primarily to state policy decisions regarding payment methodologies and an unwillingness to pursue delivery system reconfigurations. NHIC has responsibility for efficient management, including appropriate use; and in this area, it appears that NHIC has performed well.

2. Redwood Health Foundations

A second example of carrier capitation is Redwood Health Foundation (RHF), a joint venture of the Foundations for Medical Care of Sonoma, Mendocino, and Lake Counties in California. RHF has contracted with the State Department of Health since 1973 to pay all health care claims for all public assistance beneficiaries in the three counties. Thus, in contrast to NHIC, this carrier is responsible for long-term care as well as acute care. It is similar to NHIC in that the recipient's choice of providers is not restricted.

RHF's administrative fees and monthly capitation payments are determined in negotiations. The negotiated monthly premium/per beneficiary varies by category of aid (the medically indigent are not part of this arrangement) and covers the entire Medicaid benefit package as well as out-of-area use. Providers are paid on a fee-for-service basis in which the amounts are authorized by the Medi-Cal program.

Since RHF is at risk for costs above the premium, the Plan, which has no resources to speak of, has transferred the risk to those physicians, pharmacists, podiatrists, psychologists and physiotherapists that agree to go "at-risk" for the losses and gains.

RHF's has utilization and quality control mechanisms, much like IPAs, for both institutional review and provider review (by review committees specific to that provider group). These provider or peer review groups continually meet to establish norms. The utilization monitoring includes individual claims review and provider profiling. Institutional review is done by the local PSRO, whose funds were supplemented by RHF after 1981 to assure full concurrent review.

State and private studies have shown that Medi-Cal costs per enrollee for Redwood Health Foundation are below the state average and the average per enrollee in comparable counties. The lower costs have been attributed to lower use of expensive services, i.e. hospital days, outpatient hospital visits, and emergency room visits. When compared to prepaid health plans (PHPs) in the state, the costs of RHF are slightly higher. However, since RHF does not have marketing costs, and consequently its administrative costs are lower than PHPs, a higher percentage of RHF payments go to health care services.

The lower costs of the PHPs may result from how the state sets the rates for PHPs and RHF. If the state wants to achieve even lower costs with RHF, it has the opportunity to do so in their premium negotiations. In view of RHF's lower risk and administrative costs, RHF may be able to reach the PHP cost level by intensifying its utilization review, such as preauthorization approval for hospital care, and by imposing sanctions on physicians that are high utilizers. Left alone, RHF has little reason to press for savings much below the negotiated capitation rate.

C. Lessons from the Geographic Carrier-at-Risk Systems

The first and most important lesson that can be derived from these experiences is that carrier-at-risk capitation models can operate over a long-period of time in a stable and efficient manner. Secondly, while administrative costs are higher in this model than when the carrier is acting only as bill payer, the additional costs are more than offset by expenditure reductions resulting from more efficient claims auditing and utilization review. Finally, even limited risk, in terms of a percentage of premiums, can motivate cost consciousness by carriers. However, much needs to be learned about how the level of risk affects the behavior of such organizations.

The two major problems with this model as it currently exists are: the limited mechanisms available to the carrier to achieve cost reductions and the negotiation of a "fair" premium. Both NHIC and RHF operate efficient and effective utilization control programs. While additional utilization controls and review techniques are possible, other policies that could reduce expenditures significantly, e.g. reimbursement and limits on provider participation, are not available to them.

Finally, having one carrier serve an entire area places the entity in a monopoly position. Texas' attempt to secure the best price was to have a competitive bid for the contract. However, in the last round, only NHIC applied. This may reflect the previous politics surrounding the awarding of the contract, or the advantages of an existing contractor. In this regard, it is important to note that there were six bidders for the contract to become the Administrator of Arizona's AHCCCS system. The Texas situation, then, may reflect circumstances peculiar to it and may not necessarily predict what would happen with a national competitive bidding process. Moreover, there are only a few places in the country where carriers can benefit from developing the capability to go at risk for Medicare or Medicaid utilization. If Medicare were to implement a national carrier-at-risk program, it is likely that many large insurers and other entities would develop the capability to compete for the business.

A Carrier-At-Risk Physician Payment System

While there is no existing model for a geographic-based system in which a carrier is at risk only for physician and other ambulatory services, the Texas and Redwood experiences suggest that such a system is possible. Furthermore, it could be adapted to the existing Medicare program, making it a national program. Figure 2 below describes one prototype system. Medicare would benefit under a carrier-at-risk system by making Part B costs more predictable and controllable. This is especially important in view of the intensifying pressures to deliver care outside the hospital. Because of the large enrollments, the risk premium would not be based on the potential adverse selection. Rather, it would provide the carrier with an incentive to be aggressive in performing medical reviews. Because

FIGURE 2

A Carrier-At-Risk Alternative

o What Services are Included	All Part B
o Who Receives Payment	Carrier for all Fee-for-Service beneficiaries; Capitated Enrollees paid directly
o What is the Basis for Payment	Relevant Area's Historical Cost (State/ County)
o How is Price Set With Existing Carrier	Negotiated (Phase I) Competitive Bid (Phase II)
o Carrier's Policy Role	Appropriate Utilization, including PPO Development
o Federal Policy Role	Eligibility, Coverage, Payment, Quality Assurance
o Carrier Risk	Significant Risk Corridor and Risk Sharing for Part B Utilization; Shares Savings on Part A

the carrier-at-risk would not be a direct provider of care and would only receive a proportion of the savings from reduced utilization, undertreatment should not be a major problem.

With risk corridors and limited risk-sharing arrangements within those corridors, most carriers should be willing to participate. However, even with a 2 percent maximum risk exposure, this adds up to an estimated two hundred million dollars nationally. It seems reasonable to assume that this level of risk could be supported by the existing 41 carriers. Finally, over time, as more efficient and innovative carriers emerge, competitive bidding could be introduced. This should bring about a convergence in fee-for-service utilization rates around the country.

While claims and utilization review could yield substantial cost savings, they fall short of achieving maximum cost saving in both the short and long-run. The carriers-at-risk could be charged with developing innovative programs, such as ones which have efficient providers delivering a higher proportion of care. Medicare would maintain veto authority over such arrangements and beneficiaries would have to find the arrangements attractive enough to voluntarily choose them. Also, Medicare would continue to support the development of competitive, prepaid plans, having direct responsibility for their approval and monitoring.

Conclusions

The continued growth in the volume and intensity of physician services means that cost containment efforts must focus on the quantity as well as the price of physician services. Capitating physicians groups or health plans for physician services is an appealing alternative. While this capitated plan could not be implemented as a national program it may be a preferred long-run alternative to a traditional HMO. Physician capitation

programs could, over time, develop in more areas and do not embody as strong an incentive to undertreat.

A carrier-at-risk capitation system for physician services could be implemented nationally. Such a system would complement Medicare's HMO strategy, by providing an incentive to control utilization in the fee-for-service market. This system also would allow Medicare to continue benefit from its ability to hold down per case hospital payments. Finally, if incentives to reduce hospital use rates were effective, Medicare would garner a larger portion of the savings from the reduced rates.

Both of these physician capitation options will enhance the choices available to Medicaid beneficiaries. By making the fee-for-service system more price competitive with prepaid plans and by increasing the availability of prepaid plans in small towns and rural areas, a national capitation or voucher system becomes more feasible.

In addition to offering more choices, physician capitation alternatives may turn out to be the most attractive capitation programs for payers in the long-run. Because the cost savings of reduced hospitalization accrue to the government, these programs could result in lower government expenditures under Medicare. Moreover, because the government shares the risk and rewards in both the physician plans, there is less of an incentive for providers to underserve and for the government to squeeze down on the rates. By not relinquishing its role as the ultimate insurer, the government would maintain its control over major Medicare policies. However, efficient care still would result since the plans have a strong incentive to manage care under a per capita payment program.

Insert Pages 160 to 180 here

Senator DURENBERGER. All right, thank you all very much.

Let me start with a general question that probably takes off where Dr. Wallack left us, looking at the issue in terms of the priorities of policy movement on the part of the Federal Government.

It strikes me as I listen to the testimony today that the first issue we may have to resolve is whether we can wait on capitation or start moving toward some kind of a capitated system, and on a parallel track to professional, medical professional, reimbursement reform. Is that possible? And, if so, how do we lay each of those tracks? Or is it a matter of saying, "Don't even bother having the Federal Government try to get into the reimbursement reform business; leave that to the health plan marketplace. There are all kinds of experts out there that know better than we how to buy services from providers. And when you are buying a service in Rugby, ND, or in Boston, MA, you buy differently. And even the kinds of professionals, even though they may have a certain subspecialty behind their names, they practice somewhat differently in the Rugby area from the way they might practice in Boston; so why try to go through either the elaborate resource-based approach to all of these specialties or the consensus-based approach to it. Why don't we just let the health plan folks out there that are going to buy these services in the long run—why don't we let them design the payment mechanisms?"

One answer may be, "Gee, we've gone to all of this effort, financed by HCFA and all this sort of thing, to develop all these wonderful opinions. We ought to use those opinions in some way."

So, maybe what I need first from each of you is your recommendation as to whether or not we ought to wait, in effect, put our concentration on buying services from capitated plans of one kind or another, and then we will just get into the debate here with Dr. Wallack on geographic entities and how you define a group buyer. It doesn't have to be an HMO, it doesn't have to be a PPO; it could be the Mayo Clinic—you know, whatever it is. Then we will just spend our time trying to define the buyer that qualifies for our system.

Can I get just a brief reaction, starting with Janet, as to where you think we ought to be starting in this process?

Dr. MITCHELL. Well, my personal preference, as I put in my written testimony, is for capitation. And I think that is a preference probably shared by many. My concern is that we are not ready yet under Medicare to go there, and what should we do in the short run?

This morning Dr. Desmarais pointed out that, since inpatient services only account for 60 percent of Medicare part B, why bother with an approach like physician DRG's that just deals with the inpatient side? I personally think that 60 percent is a very big number and not one that should be ignored. Plus, you could combine a packaging approach like physician DRG's with one of the relative-value scales that Drs. Stason and Egdahl have discussed, to deal with the ambulatory side, until we are ready to move as a program to capitation.

Senator DURENBERGER. All right.

Dick.

Dr. EGDAHL. There is considerable uncertainty about the time-frame for capitation. As I said, I think it may be slower than we think. The primary care gatekeeper concept that Stan Wallack mentioned is potentially a good one, but we need to get experience first. Because the elderly population is the one most subject to under care, especially if the primary care gatekeeper is too parsimonious in his use of specialists and hospitalization. And I think we need to get instruments to evaluate that before we are safe in moving completely to capitation methods.

Meanwhile, if it does take considerable time, the obvious geographic disparities and some of the excessive fees simply are going to have to be dealt with. That is why we are encouraged by what Caterpillar Tractor Co. is doing. They seem to have done this without all of the tedious processes that we were going through with our consensus method.

Senator DURENBERGER. All right. Bill.

Dr. STASON. I too believe that capitation is one model that we should actively encourage for the Medicare recipients, even in the short run. It should be the only model that we are aiming for, however.

We should also retain the fee-for-service. I believe that we could in the short run, if necessary, develop a way of modifying the current distorted incentives within the fee-for-service market.

Moreover, I think that the option of a regional cap on physician expenditure—which is not that different from what Stan suggests—is something that we ought to consider very seriously.

Senator DURENBERGER. Stan.

Dr. WALLACK. I was suggesting that you could begin a national capitation program tomorrow, if you wanted to use existing carriers, and give them an incentive to run an efficient system, and at the same time, maintain the fee-for-service system. I couldn't agree more with Bill that you want to have more than capitation as an option. But, you are only going to have a fee-for-service option in the long run if the system is managed. Since insurance companies have learned how to manage the system, I believe we can have competition between fee-for-service and capitated plans.

We developed the idea of an HMO when we didn't know how to manage care; we had to put the delivery system and the insurance system together. We now have insurance companies all over the country that are learning how to manage utilization.

What I am suggesting is, that we have to think broadly about capitation. Under capitation, some entity is taking the financial risk on a per-capita basis. Don't get stuck in the idea of a traditional HMO; but think of capitation from your point, that is, as a payer, what would you like the system to look like. You could have insurors or another entity, manage the system and create the savings.

In the long run, you have got to have a fee-for-service system competing with a series of HMO's, CMP's, and hopefully, physician plans.

I personally believe that this geographic model—can eventually, through utilization controls and management, effectively reduce costs so as to be competitive with HMO's. If so, this would result in a real choice in the long run for Medicare beneficiaries.

So, I believe if we think broadly about the concept of capitation, we can start to think about covering the country a lot faster.

I do think the model of a physician group is an exciting option for rural areas. I think the only way physicians can prosper in rural areas is by letting them receive capitation rates. Otherwise, they have to inappropriately hospitalize their patients. If we can develop flexible models, ones that can prosper in rural areas, we can expand the concept.

However, one of the problems with physician capitation, is that most plans probably will not prefer it because they make their money from reductions in hospital days. But you are not making any money, in fact, you are probably losing money under the TEFRA Program. And I think you are going to have to face this from a policy control perspective.

This is a key time for you to make decisions. We don't have to encourage groups to become HMO's anymore; the interest is there. And, they all want to do it their way. I think it is very important now that we set the HMO policy, from the payers' perspective. What is the best model? How do we want to set the risk-sharing?

I think capitation happens very fast, because we no longer have the supply constraints. In Minnesota, where there is one of our social HMO projects, and in other localities such as the one mentioned in Florida, beneficiaries face no co-pays. That is happening because HMO's can be efficient, they also are getting healthier people.

So, the competition is possible. I think we have to direct it in order to get what we want, and not let ourselves just be driven by the provider system.

Senator DURENBERGER. John.

Senator HEINZ. Mr. Chairman, thank you very much. First let me commend you on holding this hearing. This is an area that I know you and many of us have substantial interest in, trying to sort out the options to see if there is indeed a better way to reimburse physicians for both the Government and the beneficiary than the present cost-based system.

I am sorry I missed Dr. Desmarais' and Vita Ostrander's testimony; I was down at the White House for a meeting involving a subject near and dear to your heart, Mr. Chairman, the steel industry and the implementation of the program to followthrough on the President's commitment on voluntary steel import restraint. The program is alive. It is apparently in intensive care. [Laughter.]

And we look for its recovery.

I do have some questions, both for Dr. Desmarais and Vita Ostrander, who I see are still out in the audience. I ask unanimous consent to submit these questions for the record for their responses.

Senator DURENBERGER. They will be made part of the record, and I assume they will respond.

Senator HEINZ. I thank you.

It is also good to see Janet Mitchell here, who testified before the Special Committee on Aging about a year or so ago.

Dr. Mitchell, you will recall that hearing; it was on Medicare physician payment options.

To the best of my recollection, you, at that hearing, testified in favor of a program to be tested implementing a DRG Program for physicians. Is my recollection right? If it is right, judging from what I gather you said, have you changed your mind in terms of going ahead with a demonstration program of some 5 years, as you suggested?

Dr. MITCHELL. No, Senator, I haven't, and you certainly do have a remarkable memory.

Senator HEINZ. I have a good staff, too.

Dr. MITCHELL. Yes, I did recommend that a demonstration be conducted. I would still recommend such a demonstration be conducted. There are, however, a couple of problems with conducting a demonstration. The first is that physician participation in the demonstration would have to be mandatory at the market-area level, and it is my understanding that HCFA does not feel it can do this without a clear directive from Congress, from you. So, that is a major problem, and I think a voluntary demonstration is worthless.

The second problem that we talked about last time is that a demonstration would take up to 5 years before we got definitive results on the impact of physician DRG's on utilization, quality, access, et cetera.

I think at this point in time I would prefer to see that we do something—whether it is physician DRG's or fee schedules—rather than continue with the fee freeze for another 5 years.

Senator HEINZ. I don't know that anyone has proposed a 5-year fee freeze, but Senator Durenberger reminds me that Gramm-Rudman might produce such a result.

So, maybe I should rethink my assumptions.

I was reading the Washington Post this morning, though, and I wasn't sure that it was going to prevail.

On the merits of DRG's for physicians, how can we be assured that physician DRG's aren't going to creat incentives to underserve patients? What I get worried about—you have got a hospital DRG and a physician DRG. We are learning some very disconcerting things about hospital DRG's, where there is clearly an incentive to underserve, particularly the older, least healthy Medicare beneficiaries. What happens if we get a physician DRG/hospital DRG alignment where the two of them end up together in falling victim to incentives to skimp on medical care, in effect removing what we now believe to be, or what we hope to be, a very important quality-assurance mechanism, namely the doctor and his or her oath to render professional medical care?

Dr. MITCHELL. Well, I agree that the skimping incentives inherent in the Prospective Payment System are a very real concern; but I find it disconcerting that we would expect to offset those skimping incentives by allowing physicians to bill fee-for-service. I don't think that the way to ensure quality of care in the hospital setting is to have physicians act as a watchdog on the hospital.

In other industries, generally, the people involved in producing the product—in this case, the hospital admissions—work together under shared incentives.

I think we also need to keep in mind that, with declining admissions and with increased physician supply, both hospitals and physicians will have to compete for patients. And since they can't do

that based on price with a fixed DRG rate, they would have to do so on quality. But I agree, that is not a complete answer.

Senator HEINZ. In my State of Pennsylvania, the biggest problems we have with the DRG hospital payment system is where there is the least competition; it is in the more rural, less metropolitan areas. And there is a lot of America that is so served, where competition as we would define it really is not practical; it doesn't exist.

Let me ask Dr. Wallack a question. One of the problems that you mentioned with the current AAPC payment for HMO risk contracts is that it doesn't take into account the health status of the enrollees. What can be done to include a valid measure of health status?

Dr. WALLACK. I think a number of things can be done. At the Health Policy Center, which is one of the major HCFA policy centers, we are working on issues of how to revise the AAPCC. There are alternatives for incorporating health status. First, we can try prior utilization.

I think, you want to identify not just utilizers, but the chronically ill people. Those are the people who are likely to cost more money over time, since chronic illnesses persist in the future. You can identify those people through their prior utilization using the diagnosis. That is one alternative. Another alternative is disability or level of functioning. We have worked with this measure and have made some suggestions to HCFA. I hope there will be some changes in the AAPCC, because without health status adjustment HCFA will be over paying. It is an important adjustment, however, I doubt we will ever be able to have a perfect health status adjustment. And that is why, to some extent, we must explore partial capitation. In summary, I think we can make real improvements.

Senator HEINZ. Dr. Stason, you talked about a relative value scale that could be used with a capitation system for Medicare. Could you elaborate on that?

Dr. STASON. Yes. As you know, one of the chief arguments against continuation of the fee-for-service system is that it offers no inherent constraint on utilization. If one is going to control costs as a major objective, control of utilization is probably even more important than the control of the fee for any given service.

It seems to me that a regional cap would be a way of spreading the risk, over high-risk and lower-risk elderly people, and hence be a much more equitable way of assuring predictable costs than a capitation fee based upon individual assessments.

Senator HEINZ. Could you elaborate on the way the resource-base affects the relative-value scale?

Dr. STASON. Our work with a resource-based relative-value scale has shown that significant disparity exists between relative values calculated on the basis of current charges and those calculated from resource inputs—in the direction of favoring surgical and diagnostic procedures over cognitive and preventive medical services by a factor of three or more.

By implementing a resource-based relative-value scale as the basis for physician reimbursement, we would balance or at least, take a major step toward balancing incentives for the use of medical procedures and medical technologies and primary care and pre-

ventive services. Control of the current excessive use of medical technologies would be one objective.

Senator HEINZ. One last question, and this one is for Dr. Egdahl.

Dr. Egdahl, I gather you testified about the drawbacks of several different payment systems, including a fee schedule developed from a consensus process. Would you reiterate for me the characteristics of a desired system from your perspective, one that you would like?

Dr. EGDAHL. Well, we were attempting and were on our way to developing such a system, which was to take the current disparities and come up with a schedule that a group of surgeons and internists would say is fair, that doesn't deny access to anybody, that eliminates some of the excessive fees, and eliminates the geographic disparities that do result in problems.

We started along the line, but clearly this seemed to be something that would take several years. What we came across with Caterpillar Tractor Co., to my knowledge, is unique. There is an individual who for several years has been doing informally with panels of doctors, what we were doing formally, and has come up with a set of fees that has accomplished both the geographic as well as the excessive fee changes I talked about, and ensured—because that was his principal function—access for all of the employees of the company and their retirees to high quality specialists and generalists, while preserving good relationships with the physicians in the areas that he worked.

Senator HEINZ. I have two other questions for you, but in the interest of time I am going to ask unanimous consent that the chairman submit them to you for answers in writing, if we may, Mr. Chairman. I know you have a lot of witnesses. This is, however, an absolutely vital as well as fascinating subject. And as with most medical issues, the deeper you get, the deeper the hole. You wonder where the discussion will end. But it is a very good panel you have brought to us, and I know you have two other good panels.

Senator DURENBERGER. Thank you very much, not only for those comments but for being here to share those insightful questions.

We have a set of detailed questions some of which are from John and some of which are from Bob Dole, some from me and some from Max, and I think Bill Bradley wanted to ask some questions, too, and there may be others, to try to compare the approach of each of you experts and to make the record complete on transition. We will ask you those questions to get some precise answers that we can compare, and we will ask you all of those questions for the record.

But I have one question that I sort of started to ask when Vita was up here, and that deals with, again, the cart and the horse kind of thing.

As we approach the issue of physician reimbursement, should we also not be thinking about laying another track in terms of benefit restructuring or restructuring the overall approach to the package of services that we are encouraging the elderly, the disabled, the chronically ill, whoever, to buy as part of Medicare coverage? Or is that an issue that we can just put to the side—don't even worry about it. If you want to do some benefit restructuring of one kind or another, do it or don't do it. Does this really have nothing to do

with the issue of physician or other professional medical reimbursement? I would like each of your views, if you can, on the possible relationship between those two.

Janet.

Dr. MITCHELL. Senator, could you clarify the kind of benefit restructuring that you might have in mind? Because obviously the kind of restructuring would influence its implications for physician reimbursement.

Senator DURENBERGER. Well, I was going to leave that to your imagination. I mean, I could start with something, you know, as drastic as I suggested to Vita in my question of her—combining part A and part B, just pulling it all together. Or, if you had a catastrophic in place.

A lot of these questions deal with the fact that we keep leaving out of this equation here the consumer and the way that consumers make decisions. We are sitting here talking as though we are setting up *x*-dollars for this service and *x*-dollars for that service, and that is all there is to it. The reality is that there are a whole set of consumers out there that, when they look at this system, they are the ones that interface with the doctors, and they are the ones that interface with the system in one way or another. And so, what they are willing to buy and how they are willing to make that buy, does have something to do with the way we as the payor decide to structure our payment schedule, or it may. When we are dealing here with the buying of a doctor or the paying of a doctor, if there isn't anything like that, putting in preventive benefits or putting in catastrophic and making us pay for catastrophic out of copays, what should we do? That is when I am talking "restructuring." Those are just some of those kinds of things you can talk about in terms of restructuring the benefits.

Dr. MITCHELL. All right. I would like to focus in particular on your suggestion of combining part A and part B, because I think that that distinction is an arbitrary one and it has grown more arbitrary over time, especially under Prospective Payment when physicians' services formerly billed through the hospital have not been forced outside the hospital.

From an efficiency standpoint, it makes far more sense to combine parts A and B, (which would happen under most capitation arrangements) and allow some gatekeeper to decide on the proper mix of hospital and physician services.

But I would like to point out one physician reimbursement reform that would fit in with a redefinition of part A and B, and that is those physician services provided in the hospital setting over which the beneficiary has no control—and those are pathologists, radiologists, and anesthesiologists. These are physicians that are called in at the request of the attending physician to provide services to the patient, but which the patient must then pay for under standard part B arrangements.

Anesthesiologists, for example, are clearly necessary for the performance of most operations. I am sure all Medicare patients would want to have an anesthesiologist, but they aren't given the choice of which anesthesiologist they would like.

Senator DURENBERGER. Could I stop you right there, Janet? I think I am getting an answer to my question with regard to that,

but at that point I need to ask you another question, and maybe the other three can respond to that one as we get to them: Why don't we just expand the hospital DRG to include all of those people that we talked about?

Dr. MITCHELL. That is exactly what I would recommend, Senator.

Senator DURENBERGER. All right. Great. And then we will deal with all these other things on the other kinds of physician services.

Dr. MITCHELL. Yes.

Senator DURENBERGER. Would you say, pay the hospital? I mean, just incorporate it into the hospital DRG, and give the check to the hospital?

Dr. MITCHELL. For those particular specialties?

Senator DURENBERGER. Yes.

Dr. MITCHELL. Absolutely. And I would just like to point out that anesthesiologists, for example, have one of the lowest assignment rates and the lowest Medicare physician participation rates, as well as the highest income. So, bundling that particular specialty in with the DRG rate would have obvious implications for reduced beneficiary liability.

Senator DURENBERGER. Then, if we let Barney and all the other people who do our buying for us out there get at those anesthesiology rates and all that sort of thing through a DRG, we might get some efficiency into the system.

Dr. MITCHELL. And definite savings for beneficiaries.

Senator DURENBERGER. I don't know what the order here is, but, Dick, are you next in the way we do this?

Dr. EGDAHL. Yes. Just commenting on Jan's suggestion, I am not sure there is a continuum from anesthesiologists and pathologists, (many with outside offices) to other kinds of private practices. Unless there is an organized group practice that can negotiate as a corporate unit with the hospital to divide physician fee moneys, I see many problems and strife with a capitation system.

As far as benefit restructing is concerned, I think the biggest problem for the future is the continuum—from acute care to long-term care to home care—that the current design does not deal with as a whole.

Industry is also now concerned about costs, as is Government. Previously, industry has been cost shifted to by everybody. This situation is becoming intolerable to them, and unless Government and industry work together, progressively greater numbers of both elderly as well as poor people who aren't elderly will slip between the cracks.

So I think one has got to view home care, long-term care, and acute care as a continuum, especially with the elderly. We can no longer look only at acute hospital care, because so many of these problems are chronic, and you sometimes convert a situation into acute care that doesn't have to be because there is no coverage for home care.

Senator DURENBERGER. Before you leave, do you want to introduce the mayor of Morton, IL?

Dr. EGDAHL. Dr. Hertenstein? Right here.

Senator DURENBERGER. Great.

Bill, I guess you are next here.

Dr. STASON. I would agree wholeheartedly with Janet, that there would be real advantages to folding reimbursement for pathologists and anesthesiologists into part A. Radiologists, some of whom who are hospital based and others office based, would be more problematic. You might have to have a double standard for radiologists, depending upon their primary practice location.

The changes in the medicare benefit package that I am most concerned about relate to the long-term care spectrum. Most important, we need to develop options, and create incentives, for use of the more cost-effective long-term care alternatives. Home care support, foster homes, and respite care are among these.

Catastrophic insurance should certainly be an element in any reform of the Medicare package.

And, finally, as I said before, I am very much in favor of emphasizing benefits that will move care to the outpatient setting and favor the judicious use of primary care and preventive medical services.

Senator DURENBERGER. You still haven't answered the question, which is: Are there any restructuring issues that it would be helpful to decide before we put packages out there to reimburse physicians—either capitated packages or something else? And I guess I am getting the impression that, so far at least, that, no, we can go ahead with this changing the payment system, and you can restructure your benefit package, and there are some good restructurings out there.

I come to this principally by watching the outpatient surgery thing. Everybody says, "Let's get it done in the most efficient place." So, there are 150 already on line, and there might be another 1,000 behind them, and we are sitting here talking about changing the facilities payment and then maybe we will get to changing the doctor payments, and all that sort of thing. And the poor folks out there don't really know what it is they are buying.

But that just suggests to me that there is an element in here. I mean, a lot of these entrepreneurs, if you will, in the facilities-based delivery systems are doctors, and they are people who used to work in little boxes inside a big box called a hospital, and they found out that the hospital was ripping them off to subsidize somebody else, in fact, so they went outside to compete. And they are making a lot of money. Or, we catch them making money, and we rachet them way down, and we take all the incentives away from them.

So, I ask this question because it seems to me that when we talk about physicians, we are dealing with the key element in this whole delivery system. These are the people that know best how to deliver care. And whether they deliver it in a hospital or in an outpatient setting or at home, or wherever, these are the folks that know what they are doing, and maybe we are getting in the way of their doing it more efficiently by this limited package of benefits that we are offering to people and we ought to restructure that before we move in the direction. I don't know this to be the case, but that is the question I am asking.

Stan.

Dr. WALLACK. I think we have all answered the question by looking at cutting costs in different ways. I think there are three ele-

ments that have been addressed; one is the administrative side. Clearly, with the DRG system and paying flat national rates, it makes sense to put the carrier and intermediary concepts together. The program will run more efficiently, and the beneficiary would benefit from one administrator.

You then have the issue of pricing, and today I have said I think a capitation payment around physician services is peferable, because they are the gatekeeper.

The third issue is benefits. Clearly benefits cost money. I would support catastrophic benefits expansion. I think the notion of the break between chronic and acute care is one that can be dealt with. I don't think you have to go all the way to unlimited long-term care. A very small percentage—approximately 10 percent of the elderly consume 90 percent of the long-term care.

Senator DURENBERGER. And we are shoving them into the State Medicaid systems, though.

Dr. WALLACK. Yes. We can talk about innovative, public or private solutions for that; but there are chronic care needs as opposed to long-term care. Medicare should be a program for the older people; it should have a set of chronic-care benefits that make more sense for this age group.

Senator DURENBERGER. Right.

Dr. WALLACK. So, I greatly support that. Now, whether you can do that, I don't know; it costs money, as I said, but it makes a lot more sense.

But, as you know, we are getting these kinds of innovations within HMO's. They are attracting people not only through lower price, but also through more benefits, particularly options like drugs.

Coming back to the geographic model, I would view a model like that as potentially expanding benefits as well. It seems to me, under this idea of a geographic cap or regional cap, you have the traditional Medicare Program, but then you also say it isn't a very good program, because it has some problems. Why don't we have options that make it attractive for people to use certain physicians, such as the PPO concept? Why don't we have other incentives that make it attractive for people to move into a case management system and have some benefit increases if they move into one, such as drugs, and home health care?

So, I see the potential, with an intermediate-at-risk, or carrier-at-risk system, of expanding the benefits. I think it would be cost-effective, because there are a lot of savings possible. Finally, you would be making Medicare a better program while still maintaining the fee-for-service system and freedom of choice.

Senator DURENBERGER. Well, I am glad we touched on this issue, because, again, everybody in this room is trying to think positively about how to do this better for the benefit of the elderly and the disabled, and I think it is good to keep it in the larger context.

As I indicated earlier, there are a series of questions that we are going to ask you all to respond to, and I hope you will do it fairly quickly, because I am going to explain to the staff that I would hope we could get out some kind of a print on this hearing as soon as possible, just to stimulate more discussion and more input across

the country into this issue, so that, hopefully, it might be something we can deal with substantively in the coming year.

So, you have our gratitude for the work you have put in so far and our anticipation of our being grateful for your future work.

Thank you very much.

Our next panel, our last panel, consists of Dr. Jim Davis, speaker of the American Medical Association House of Delegates from Durham NC; Dr. David Utz, FACS, professor of urology, Mayo Clinic and Mayo Medical School at Rochester, MN, on behalf of the American College of Surgeons; Dr. Tom Connally, the chairman of the Governmental Affairs Activities for the American Society of Internal Medicine; Dr. Edith Irby Jones, the president of the National Medical Association of Houston, TX.

I read off four names and eight people appeared—no, seven. We welcome you all. Joe, good to see you back again.

You now know the procedure, and you know some of the trends that we are looking for. Your full statements, which are all excellent statements—I looked at them last night—will be made part of the record, and you may proceed now to summarize those statements. We will begin in the order of introduction with Dr. Davis first.

STATEMENT OF JAMES E. DAVIS, M.D., SPEAKER OF THE HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION, DURHAM, NC, ACCOMPANIED BY: HARRY PETERSON, DIRECTOR OF THE AMA DIVISION OF LEGISLATIVE ACTIVITIES

Dr. DAVIS. Thank you, Mr. Chairman.

My name is James E. Davis, M.D. I am a physician in the practice of general surgery in Durham, NC. I also serve as speaker of the house of delegates of the American Medical Association. Accompanying me today is Harry Peterson, director of the AMA's division of legislative activities.

Mr. Chairman, physicians in this country have continued to provide high quality services to Medicare beneficiaries and the rest of the population, even in the face of the current Medicare fee and reimbursement freeze, and rapidly rising expenses in professional liability insurance and other practice costs.

The AMA continues to urge physicians to consider each patient's financial needs when setting charges and to accept Medicare assignment, reduced fees, or charge no fee at all in financial hardship cases. This has been beneficial to Medicare beneficiaries, and the assignment rate, as you have heard, has continued to climb. By last summer, it was over 69 percent of all Medicare claims accepted under assignment, although only 30 percent and perhaps now 28 percent of physicians elect the participating status.

The AMA does not believe that further drastic cuts in physician reimbursement under Medicare are appropriate, especially in light of the long history of cutbacks in this aspect of Medicare and the potential negative impacts that further cuts may have.

The AMA is gravely concerned over recent actions modifying physician reimbursement under Medicare, and is especially concerned over the potential future directions being considered and

the implications for Medicare beneficiaries and the physicians who provide their care.

The American Medical Association believes that a freeze for an additional year will aggravate the disparity between income and expenses for physicians and lengthen the already substantial time-lag in reflecting changes in reimbursement.

A continuation of the fee freeze and reimbursement limitations will be particularly onerous and will work particularly severe hardships on physicians and their patients in situations where the physicians' fees have been frozen at a relatively low-charge rate, and where physicians did not increase their fees during the AMA's voluntary fee freeze period.

Failing to allow increases in physician reimbursement, as currently provided in the law, also will be contrary to a congressional commitment. Mr. Chairman, continued freezes should be rejected.

The AMA supports research and demonstration projects to examine various methodologies for physician reimbursement. Without adequate study, stopgap quick fixes to perceived problems in current methodology will be detrimental to the goals of providing health care services of high quality and continued improvement in overall health status for elderly and disabled patients.

One methodology of physician reimbursement being studied is to base payment on a fixed cost, based on diagnosis. Even if such a plan were administratively feasible, we have grave questions over how it would affect the quality of care.

Perhaps a most serious drawback to a DRG-based payment system for physicians is that it could break down the essential role of the physician as a health care advocate for the patient. We never want to see the day when the best physician would be viewed as one who was the most cost effective, as opposed to the one who provided the best individualized care.

We strongly object to a DRG system for physician reimbursement, especially in the absence of demonstrations proving that the above concerns are unfounded.

The AMA is working with Harvard University on the development of a relative value study, RVS, to establish resource cost-based relative values for physicians' services, of which you have already heard. This study has been approved by HCFA, but final contracting has not been forthcoming. We urge HCFA to initiate this important research program and hope that Congress will await the results of this activity prior to the imposition of substantial modifications in physician reimbursement under Medicare.

An RVS of this type could ameliorate many of the uncertainties in current Medicare reimbursement, and it could allow for greater competition by offering patients a greater understanding of the charges for each service.

The AMA believes that there is merit to the voucher concepts. However, while a capitated approach offers many benefits in theory, we believe that any program change of such magnitude should be studied through demonstrations in a number of areas.

In conclusion, Mr. Chairman, Congress made a major commitment that the health care needs of the elderly will be met. We are concerned that continued cuts in Medicare will deny the fulfillment of this promise.

Medicare services are relied upon by over 30 million people, and proposals under consideration by this committee will set program direction for years to come. Actions taken to modify the reimbursement system for the many physicians who provide care to these beneficiaries will have wide-ranging repercussions, and they should only be made on the basis of careful thought and complete analysis.

Mr. Chairman, we appreciate very much the opportunity of testifying today. The American Medical Association would be very pleased to be a continuing part of the process of determining which is the best and most equitable method of reimbursing physicians.

Thank you, sir.

Senator DURENBERGER. Thank you very much, Dr. Davis.

Dave Utz.

[Dr. Davis's written testimony follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Finance
United States Senate

Re: Physician Reimbursement under Medicare

Presented by: James E. Davis, M.D.

December 6, 1985

Mr. Chairman, and Members of the Committee:

My name is James E. Davis, M.D. I am a physician in the practice of general surgery in Durham, North Carolina. I am also the Speaker of the House of Delegates of the American Medical Association. Accompanying me is Harry N. Peterson, Director of AMA's Division of Legislative Activities.

The American Medical Association is pleased to have this opportunity to appear before this Committee to address physician reimbursement under the Medicare program. We are gravely concerned over recent actions modifying physician reimbursement under Medicare, and we are even more concerned over the potential future directions being considered and the implications for physicians and their patients.

Mr. Chairman, at the outset let me assure you that physicians have continued to provide high quality services to Medicare beneficiaries and the rest of the population -- even in the face of the fee and reimbursement freeze and rapidly rising expenses in professional liability insurance and other practice costs.

Moreover, the AMA remains strongly committed to real reductions in health care expenditures. In response to an AMA call to all physicians in February 1984, physicians voluntarily agreed to freeze their charges to all patients, not just Medicare beneficiaries, for a one-year period. Compliance with this freeze was substantial, with 63% of all physicians not raising their fees for the entire year that the fee freeze request was in effect. The resulting savings from this voluntary activity was an estimated $3.1 billion dollars that otherwise would have been spent for physicians' services. The voluntary freeze was a significant factor in the recent slow-down in the rate of increase in the cost of physicians' services and in the over-all decrease in the nation's spending rate for health care services.

Even though the one-year voluntary fee freeze period has expired, the AMA continues to urge physicians to consider each patient's financial needs when setting charges and to accept Medicare assignment, reduce fees, or charge no fee at all in financial hardship cases. This has been beneficial to Medicare beneficiaries and the assignment rate has continued to climb: over 69% of all Medicare claims now are accepted under assignment, although only 30% of physicians elected the "participating" status where they are obligated by law to submit all claims on an assigned basis.

Physicians have kept faith with the Medicare program and their Medicare patients. This has occurred even while the level of physician reimbursement under Medicare has not kept pace with the rest of the economy and reimbursement under other programs. This is borne out by the fact that Medicare recognized less than 20% of claims submitted in 1984 as being at or below the "prevailing" charge screens. Nevertheless, the percentage of physicians treating Medicare patients also has remained relatively constant, with 85% of physicians treating Medicare patients in 1984.

Mr. Chairman, physicians today are facing a crisis of nightmare proportions caused by increases in professional liability litigation that in turn have caused a lack of available insurance coverage at reasonable costs. This professional liability crisis poses a substantial threat to the very ability of our nation to meet the medical needs of our people. The AMA is supporting federal legislation introduced by Senator Hatch (S. 1804) to encourage states to enact tort reforms to avoid a paralysis of our health care system brought about by the increasingly threatening litigation climate. The proposal supported by the AMA would assure compensation for those who are injured through negligence.

The AMA does not believe that further drastic cuts in physician reimbursement under Medicare are appropriate, especially in light of the long history of cutbacks in this aspect of the Medicare program and the potential negative impacts that further cuts may have on the individual physician's willingness to continue involvement with the Medicare program. (For the Committee's information, the attached appendix to this statement details the history of curtailments in physician reimbursement under the Medicare program.)

CONTINUATION OF CURRENT MEDICARE LIMITATIONS IN REIMBURSEMENT AND FEE FREEZE

The AMA consistently has opposed the recent activities of Congress to freeze physician fees and reimbursement for physician services under Medicare as being unfair and discriminatory.

The Fee Freeze and Reimbursement Freeze are Discriminatory - In the budget cycle for FY85, the only freeze imposed in federal programs was placed on physicians. Other elements of the economy have not been asked to undergo similar restraints in payment from the federal government. An extension of the freeze would be particularly discriminatory as only physicians would be subjected to a two-year freeze. Although inflation has abated since the double-digit levels of the late 1970's, a freeze for an additional year will aggravate the disparity between income and expenses for physicians and lengthen the already substantial time lag in reflecting changes in reimbursement.

Selective Increases in Reimbursement are Inappropriate - Failure to allow increases in physician reimbursement as currently provided in the law will be contrary to a commitment made by Congress.

As evidenced by provisions recently considered in the current House/Senate budget reconciliation process, some Members of Congress apparently believe that only currently "participating physicians" are owed an increase in reimbursement under Medicare. Furthermore, "participating physicians" were given favorable treatment under the Deficit Reduction Act of 1984 as their fee profiles were intended after October 1, 1985 to reflect increased charges made during the original

fifteen-month freeze. Allowing an increase in reimbursement only for "participating physicians" would perpetuate and aggravate the current discrimination in the law.

Congress should not again break faith with physicians who acceded to inequitable reimbursement levels on the basis of a limited duration. Such a breach of faith was exemplified in those provisions of the "Emergency Extension Act" that require a rollback of actual charges by physicians who "participated" in FY 85 and who decided not to "participate" in FY 86, and that continue the fee freeze.

Continuation of the Fee Freeze and Reimbursement Limitations will Harm Patients of Low-charge Physicians - The current fee and reimbursement freeze has already resulted in some physicians finding it difficult to continue treating Medicare beneficiaries. This would cause a break in physician-patient relationships as such patients are forced to seek care from others. A continuation of the fee freeze and reimbursement limitations also will work particularly severe hardships on physicians and their patients in situations where the physicians' fees have been frozen at a relatively low charge level, and where physicians did not increase their fees during the AMA's voluntary fee freeze period. These physicians will be penalized for their good faith effort to hold the line on health care expenditures.

Acceptance of Assignment will be Discouraged - A continuation of the Medicare reimbursement limitations and the fee freeze will discourage physicians from accepting Medicare claims on an assigned basis. This would be contrary to the intent of Congress and could well reverse the

current trend of increasing rates of assignment. Continuing a trend started in 1976, the rate of assignment of claims has steadily increased from 51% in 1976 to 69.4% in August 1985.

ADDITIONAL REVENUE

The AMA also believes that additional sources of revenue should be used to avoid further cuts in important health care programs. Specifically, we support an increase in the cigarette tax to 32¢ per package. This increase would generate an additional $6.5 billion in revenue. We also support an increase for the tax on distilled spirits. These revenues could be channeled to the Medicare trust funds and eliminate the need for heavy cuts in these important programs. This action would both discourage abuse of alcohol and tobacco and it would help fund the care required for alcohol and tobacco related illnesses.

ALTERNATIVE PHYSICIAN PAYMENT METHODOLOGIES

While the AMA does not support a continuation of inequitable freezes in physician reimbursement, we do recognize that changes in the Medicare program's physician reimbursement methodology may improve program administration and benefits for patients, those who provide their services, and the federal government. We support research and demonstration projects to examine various methodologies for physician reimbursement. Such projects and studies are essential if there is to be a fair and successful modification in how physicians are paid for their services. Without adequate study, stop-gap quick fixes to perceived problems in the current methodology will be detrimental to the goals of providing health care services of high quality and continued improvement in overall health status for elderly and disabled patients.

The AMA fully supports a pluralistic approach to the payment for physician services. We believe that an indemnity payment system should be viewed as a preferred policy for setting physician reimbursement.

Physician Payments Based on Diagnosis Related Groups (DRG)

One methodology for physician reimbursement being studied is to base payment on a fixed cost based on the patient's diagnosis. This concept is the focus of a congressionally-mandated study by the Department of Health and Human Services that was due by July 1985 but has yet to be released.

Just as we have continuing concerns over the hospital DRG payment program, we have strong objections to a DRG-based physician payment plan. Even if such a plan were administratively feasible, we have grave questions over how it would affect the quality of care. A DRG system inherently gives substantial incentives to limit care. The DRG methodology of payment also fails to take into account severity of illness. This causes particular problems for those physicians who, because of specialized skill and training, see patients with the most severe illnesses. Since the DRG methodology is based on "averages" and individual physicians (unlike hospitals) do not ordinarily have a large enough patient population with identical diagnoses to enable costs to be spread over a larger base, a DRG system could operate as a disincentive for physicians to accept critically ill patients and could discourage necessary use of consultants.

We also must oppose any program where all services to hospital inpatients would be based on DRGs and payment would be made through the hospital. It is evident that if both hospital and physician payments are

based on a predetermined amount, all of the economic incentives will be strongly directed toward under-provision of care.

Perhaps the most serious drawback to a DRG-based payment system is that it could break down the role of the physician as the health care advocate for the patient. We never want to see the day when the "best" physician would be viewed as one who was the most "efficient" as opposed to the one who provided the best individualized care. Because of its strong potential for adverse effects on patient care, we strongly object to a DRG system for physician reimbursement in the absence of demonstrations proving that the above concerns are unfounded.

Relative Value Studies

The AMA is working with Harvard University on the development of a relative value study (RVS) to establish resource cost-based relative values for physician services. This study was recently funded by the Health Care Financing Administration and we hope that Congress will await the results of this activity prior to the imposition of substantial modifications in physician reimbursement under Medicare.

A reimbursement system based on a resource cost based relative value study could ameliorate many of the uncertainties inherent in current Medicare reimbursement, and it could allow for greater competition among physicians by allowing patients a greater understanding of charges made for each service. Such a system could also address many inequities in payment rates for services that are inherent in the current method of reimbursement.

Capitation

There has been a significant amount of discussion concerning capitation as the principal means of administering the Medicare program. Specifically, instead of the federal government providing payment for services (through carriers and intermediaries), a voucher would be issued by the federal government and each beneficiary would purchase his or her health insurance coverage in the private sector using the voucher as payment for all or part of the premium.

The AMA believes that there is merit to the voucher concept. In such a program competition would operate to respond to the needs of the patient population. Heavy federal regulation would not be necessary to direct every aspect of the program, as there would be natural incentives for economy. Beneficiaries would also benefit from the increased freedom to choose a health benefit plan that meets their individual needs and allows them to accept increased responsibility for their health care choices.

While a capitated approach offers many benefits in theory, we believe that any program change of such magnitude should be studied through demonstrations in a number of areas. For the past two years, all Medicare beneficiaries have been the unwilling subjects of a previously untested DRG system, and serious questions are arising concerning adverse effects on quality care. Congress should not again experiment on the entire Medicare population. Instead, we urge the committee to require major demonstrations of the capitation concept before authorizing such a system to determine what effect it will have on patient care.

NEED FOR LONG-RANGE ANALYSIS AND SOLUTIONS

Mr. Chairman, there can be no doubt that the Medicare program needs substantial modifications to avoid bankruptcy in the future. Even though the date of predicted insolvency for the Medicare Hospital Insurance Trust Fund has recently been set back to 1998, Congress now should start addressing the long-range viability of the program.

The AMA has issued two major reports on the Medicare program. The first report identified a series of proposals to help assure solvency of the program for the short-term. The second report sets forth a series of options that should be considered in any reform of the Medicare program. At this time the Association is continuing its study of proposals to change funding for health care for the elderly from the current pay-as-you-go program to a fully funded system where resources will be set aside to provide real trust funds for the future. We believe that such a program could be workable.

Congress has made a commitment that health care needs of the elderly will be met. Continued cuts in Medicare will result in a breakdown of this promise.

CONCLUSION

Medicare services are relied upon by over 30 million people, and proposals under consideration by this Committee will set program direction for years to come. Actions taken to modify the reimbursement system for the many physicians who provide care to these beneficiaries will have wide ranging repercussions, and they should only be made on the basis of careful thought and complete analysis.

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Historical Perspective - Physician Reimbursement under Medicare
(November 1, 1985)

Since the inception of Medicare, Congress and the Department of Health and Human Services (formerly the Department of Health, Education and Welfare) have taken actions that have resulted in reductions in Medicare reimbursement for services provided by physicians for Medicare beneficiaries. The result of these actions has been that physician reimbursement under Medicare consistently has been compressed to a point where the maximum Medicare reimbursement rate, the "prevailing charge," usually does not reflect the actual prevailing charge for a service in a community. This is borne out by the fact that as of the end of calendar year 1984 only 18.3% of all claims were at levels either at or below Medicare prevailing charge screens. The following information details past actions that have served to limit physician reimbursement under Medicare:

In 1969, the prevailing charge was lowered from the 90th percentile to the 83rd percentile of customary charges.

In 1970, the prevailing charge was lowered to the 75th percentile of customary charges.

For the second half of the 1971 fiscal year, physician's customary charges were based on the physician's median charge during the 1969 calendar year.

In August 1971, nationwide wage and price controls were imposed. While these controls were lifted seventeen months later for most of the economy, they still were retained for physicians for an additional fifteen months -- until May 1974.

In 1972, Congress established further restraints through use of an economic index as a means to limit the rate of annual increase in prevailing charges. In 1976, the economic index was used to set the prevailing charge limits using fiscal year 1973 charge screens that were based on physicians' charges during calendar year 1971.

In 1984, the Deficit Reduction Act modified physician reimbursement in the following ways:

The act created two classes of physicians, "participating" physicians who agreed to accept all Medicare claims on an assigned basis and "non-participating" physicians who may continue to accept assignment on a claim-by-claim basis;

Medicare maximum reimbursement levels for physician services, customary and prevailing charge levels, were frozen for the period of June 30, 1984 to September 30, 1985 (If no freeze had been imposed by the Deficit Reduction Act, the economic index would have allowed a 3.34% increase of the prevailing charge level on July 1, 1984.);

The act eliminated the increase in fee profiles that should have occurred on July 1, 1984 and delayed from July 1 to October 1 any future annual increase or update in fee profiles, with the next increase scheduled for October 1, 1985; and

Fee increases for services provided Medicare beneficiaries by "non-participating physicians" above the level charged for the period of April, May and June of 1984 were prohibited during this 15-month period. (Participating physicians were allowed to increase their fees for Medicare beneficiaries, but they are not allowed to collect this increased fee because of the agreement to accept assignment on all Medicare claims.)

The Emergency Extension Act, passed on September 30, 1985, froze physician payment levels at the rates in effect on September 30, 1985 for 45-days. (This Act prevented a 3.15% economic index increase from being applied to Medicare prevailing charge levels on October 1, 1985.) This Act also rolled back the actual charge levels allowed physicians who "participated" in FY85 but who had not agreed to "participate" in FY86 to their charge levels in effect during the period of April, May and June, 1984. This Act effectively prohibited the October 1, 1985 increase in fee profiles from taking place.

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STATEMENT OF DAVID C. UTZ, M.D., F.A.C.S., PROFESSOR OF UROLOGY, MAYO CLINIC AND MAYO MEDICAL SCHOOL, ROCHESTER, MN; ON BEHALF OF THE AMERICAN COLLEGE OF SURGEONS

Dr. UTZ. Thank you, Mr. Chairman.

Members of the subcommittee, I am David Utz, a urologic surgeon in Rochester, MN. I am a fellow and an officer of the American College of Surgeons, upon whose behalf I appear before you this morning.

The college is appreciative of the opportunity to share with you the views of its members about possible reforms in Medicare payment policies.

The purpose of our testimony this morning is twofold: First, we would like to offer to this committee and place at your disposal our experience and our resources for your consideration in the development of alternative approaches for physician reimbursement.

And second, we would like to identify four principles which we believe are basic to an acceptable payment reform plan.

With regard to the first part of our testimony, the college is convinced that we must express ourselves regarding the concerns of the impact of changing payment policies on the practice of surgery and medicine.

We have strong views about the incentives that will make for good patient care at an affordable cost. We have strong concerns that other interests of the patient may be adversely affected by inflexible or rigidly applied payment changes.

In a word, Mr. Chairman, the members of the College of Surgeons want to play a very constructive role in your review of the changes in payment policies under the Medicare Program.

Our study of Medicare payment issues suggests that the first highly critical step is to assure that the plan is fair to each of the parties concerned—that is the patients, the physicians, and the Government—by defining the services for which payments will be made. Payment for any service really has no meaning unless everybody knows what is being provided, and this task, to which the members of the college have devoted considerable thought and effort, will be of great benefit, we believe, to the committee. And we feel there should be no substitute for the use of surgical experts in the technical definitions of the quality of surgical care rendered to patients.

Now, regarding the second purpose of our testimony, it is to set forth four principles which we believe to be important in the design of any broadly acceptable payment reform plan. These principles are:

First, to avoid changes in payment methodology that would result in any undesirable consequences for beneficiaries. And these might be limitation to access of care, compromises in quality of care, and burdensome increases in beneficiary costs.

The second principle is to support the best practice of medical care that is now provided and to encourage improvements in clinical diagnosis and treatment.

Third, to make future costs of services more predictable and acceptable.

And finally, to provide a system of administration that will assure effectiveness and fairness.

Mr. Chairman, there isn't time this morning to go into detail about each one of these principles, but I would like to say a few words about one or two.

Regarding the first principle—that is, to avoid the undesirable consequences to beneficiaries—the principal purpose of Medicare is to provide beneficiaries with reasonable economic protection against certain health care costs.

In establishing a new system of payment, there is a danger, we think, that the Government's cost for the program may be reduced by shifting the burden to the patient. Now, this burden can be transferred directly in monetary terms or indirectly, making it more difficult for the patient to obtain access to high quality care. And unless caution is taken, there is a very real risk that two systems of care will be established—one for the privately insured, and second, a less desirable one for Medicare and other publicly sponsored patients.

We believe that prospects for achieving the objective of beneficiary protection can be improved by recognizing reasonable variations in the level of fees paid geographically as well as according to the skill level required by a given service, or the skill level of the physician providing the care.

We recognize that excessive medical and surgical fees are a problem in some instances, and this is an issue that needs to be addressed.

Regarding the third principle, to make future costs of services more predictable, Mr. Chairman, the health care cost issues are indeed complex; but it seems possible to provide for reasonable limitations in the rate of increases. Combining services into appropriate units, as feasible, has always seemed desirable to us as surgeons, not only to avoid incentives to increase the number of services but also to permit patients to know ahead the cost of some of the major services that they will receive.

Regarding the fourth principle, to provide effective administration, the system of administration to be applied in the case of any new payment system is a key element to its acceptability and success. Therefore, we have some concerns about the suggestions of making individual physicians or hospital administrators the organizers and payors of all the complex services provided patients.

In conclusion, Mr. Chairman, the American College of Surgeons wishes to reemphasize its intention to offer assistance to the Congress, to this committee, in the development of any revisions in Medicare payment policies, and to the administration in implementing any proposals that are adopted.

We understand that economic and budgetary concerns have been major factors in recent policy actions under Medicare; but we hope that, together, we can participate in finding methods to address these issues in ways that do not disadvantage the patients, the beneficiaries, or cause unneeded and disruptive strain on the medical system itself.

Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you, Dave.

Do you want to make a comment now, Senator Boren?

Senator BOREN. No, I just wanted to join you in welcoming Dr. Utz here before the committee. He is a distinguished citizen generally in the State with whom I am acquainted, and it is a privilege to have him here. He is a leader not only in the medical field but in the educational field as well. I join you in welcoming him to the committee.

Senator DURENBERGER. Yes; if we ever goof up on the Republican side, my colleague here on my left is going to run the Intelligence Committee; so I sort of take him under my wing on a variety of things, not the least of which is health policy. I promised him I wouldn't tell my urologist story on Dave Utz, but I have to do it anyway, because it was such a wonderful experience—not with Dave. You are not a very serious professional.

But I was at a dinner up in New York, and it was one of those dinners—this was before 1982, I think. It was a dinner where there were more people at the head table than there were in the audience—one of those 400 people at the head table dinners. Bob Dole was the chief Republican, and Walter Mondale was the chief Democrat, and they were honoring a third party.

The main speaker was Danny Kaye. They started at 8 o'clock and at about 11:45 they finally got to Danny Kaye. He got up and said, "Before I deliver my speech, I want to express my gratitude to someone who is not here today, for making it possible for me to be here at 11:45—my urologist." [Laughter.]

Our next witness is Dr. Connally.

[Dr. Utz's written testimony follows:]

STATEMENT

of the

AMERICAN COLLEGE OF SURGEONS

Subcommittee on Health
Committee on Finance
United States Senate

Presented by

David C. Utz, M.D., F.A.C.S.

RE: Possible reforms of Medicare payments to physicians

December 6, 1985

Mr. Chairman and Members of the Subcommittee:

I am David C. Utz, M.D., a urologic surgeon from Rochester, Minnesota. I am a Fellow and an officer of the American College of Surgeons, on whose behalf I appear before you this morning. The College is appreciative of this opportunity to share the views of its members about possible reforms in Medicare's payment policies relating to the provision of the professional services of physicians.

The American College of Surgeons, Mr. Chairman, is a 72-year-old voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high quality care for the surgical patient. The College provides extensive educational programs for its Fellows and for other surgeons in the United States and elsewhere in the world. It also cooperates in the education of nurses and allied

health care practitioners. In addition, it establishes standards of practice, disseminates medical knowledge and provides information to the general public.

In 1918, the College established the nation's first voluntary hospital standardization program, designed to improve the level of patient care in hospitals. It supported this program with its own funds for 35 years. Out of this effort came the Joint Commission on Accreditation of Hospitals (JCAH), the nation's principal hospital survey and accreditation body of which the College is a member. To achieve the goal of excellence in the provision of quality surgical services for patients, the College also maintains strong bonds with physicians in the various surgical specialties through representation on its Board of Governors, as well as through some 11 surgical specialty advisory councils. There are 85 Chapters of the College in the United States and other countries throughout the world.

The purpose of our testimony is twofold. First, we would like to offer to this Committee, and place at your disposal, our experience and resources for your consideration in the development of alternative approaches for physician reimbursement under the Medicare program. Second, we would like to identify four principles that we believe are basic to an acceptable payment reform plan.

With regard to the first purpose of our testimony, we are living in a period of very rapid change in the organization and delivery of personal health services to patients. Much of this progress is the result of new developments in science and technology. These developments are causing profound effects on surgical care.

Surgeons are gratified to be at the forefront of clinical innovations that represent major improvements in the care received by patients in this

country. Therefore, we believe it is important to weigh carefully the impact of any policy changes in the Medicare program, including changing payment incentives, on the way surgery and medicine are now practiced, especially in view of new systems for the provision of surgeons' and other physicians' services in the future.

Many changes in the way health care is provided derive from changing payment practices by governmental and private third-party payers and from rising concerns about the overall costs of care. In the past, the American College of Surgeons was only minimally involved in these policy areas, but the College is now convinced that we must express our concerns about the impact of changing payment policies on the practice of surgery and medicine. The surgeon's relationships to hospitals, ambulatory surgical centers, health maintenance organizations, teaching and research centers are all being affected by the various incentives and disincentives incorporated into new payment methodologies. We have strong views about what incentives will make for good patient care at affordable cost; we have equally strong concerns that other interests of the patient may be adversely affected by inflexible or rigidly applied payment changes. In a word, Mr. Chairman, the members of the American College of Surgeons want very much to play a constructive role in your review of changes in payment policies under the Medicare program.

Our study of Medicare payment issues suggests that the first, highly critical step is to assure that a plan is fair to each of the parties concerned--patients, physicians and the government--by defining the services for which payments will be made. Payment for any service has no meaning unless everyone knows what is being provided. This is a task to which the

members of the College have devoted considerable thought and effort, and there should be no substitute for the use of surgical experts in the technical definitions of quality surgical care rendered to patients.

We believe that we know how good surgery and medicine should be practiced today, and how technological changes are reshaping the way in which that care will be provided tomorrow. We say this even though we recognize and understand that the pricing of Medicare services is going to be performed by a public agency, and that patients, payers and other professionals all have a role to play in the design and implementation process related to any new policies.

The second purpose of our testimony is to set forth four principles we believe to be important in the design of any broadly acceptable payment reform plan. These principles are designed:

First, to avoid changes in payment methodology that would have undesirable consequences for beneficiaries from the standpoint of 1) loss of access to care, 2) compromises in quality of care, or 3) burdensome increases in beneficiary costs;

Second, to support the best practice of medical care as now provided and encourage continued improvements in clinical diagnosis and treatment;

Third, to make future costs or services more predictable and acceptable; and,

Finally, to provide for a system of administration that will assure effectiveness and fairness.

I. Avoid Undesirable Consequences for Beneficiaries

The principal purpose of Medicare is to provide beneficiaries with reasonable economic protection against certain health care costs. In establishing a new system of payment, there is danger that the government's costs for the program will be reduced by shifting the burden to the patient. This burden can be transferred directly in monetary terms or indirectly by making it more difficult for the patient to obtain access to high quality care. Unless caution is taken, there is the very real risk that two systems of care will be established--one for the privately insured and more affluent segments of the population and a second, less desirable one, for Medicare and other publicly sponsored patients. We would hope that such unfortunate results can be prevented.

We believe that the prospects for achieving the objective of beneficiary protection can be much improved by recognizing reasonable variations in the level of fees paid geographically as well as according to the skill level required by a given service or the skill level of the physician providing the care. But we recognize that excessive medical and surgical fees are a problem in some instances and that this is an issue that needs to be addressed.

II. Support the Best Practice of Medicine

Changes in physician payment policies should support the best practice of medicine. This means that the payment system should be adapted

to the medical care system, rather than expecting the converse. Medical care practices are dynamic and changing continuously as knowledge grows and new technology becomes available. The payment system should be organized to permit changes in payment concurrently with changes in practice and to permit improvement in payment methods as experience with a new approach reveals problems and possibilities for advances. Above all, we are concerned that payment policies not impede the continuation of these improvements in clinical practice for which this country and American surgery are renowned. Unless great care is taken in the design of payment methods, advances in clinical medicine may inadvertently be seriously impeded.

III. Make Future Costs for Services More Predictable

The issues of changing costs of practice, productivity, technological and scientific advances, the quality of care provided and long-term effectiveness need to be taken into account in making payment adjustments. These issues are complex, but it seems possible to provide for reasonable limitations on the rate of increase in health care costs. Nevertheless, we do not believe in a mechanism such as DRGs for physicians.

However, combining services into appropriate units, as feasible, has always seemed desirable--not only to avoid incentives to increase the number of services, but also to permit patients to know ahead of time the costs of some of the major services they will receive. Today, most surgeons charge a fee for a surgical operation that includes a preoperative visit, the operation itself and visits after operation at least until discharge from the hospital. The College has supported for years this kind of "global" fee that packages the cognitive aspects of surgical care before, during and after the operation, including the operative procedure--

all in a single fee. The important judgmental decisions made in the preoperative, operative and postoperative periods are best performed by surgeons. We would be pleased to share our experience in efforts to apply the packaging concept in the Medicare program.

IV. Provide for Effective Administration

The system of administration to be applied in the case of any new payment system is a key element for its acceptability and success. Changes that require the creation of entirely new organizations not only would require a lengthy start-up period, but also would introduce the risk that a new agency might not perform adequately. For example, we are concerned about suggestions for making individual physicians the organizers and payers for all of the complex services provided to patients. If the attending physician were assigned such a task, he or she would be required to perform large-scale administrative duties for which many physicians are neither equipped or inclined to assume. Moreover, such assignments could introduce conflicts among physicians in arranging for the best quality care for patients.

We also consider it highly important to provide for a smooth and orderly transition from the present payment system to any changed one. This would help avoid undue difficulties for both patients and physicians, because of administratively unrealistic burdens put upon those who receive and those who provide medical care.

Conclusion

In conclusion, Mr. Chairman, the American College of Surgeons wishes to re-emphasize its intention to offer assistance to the Congress in developing any revisions in Medicare physician payment policies and to the Administration in implementing any proposals that are adopted. We understand that economic and budgetary concerns have been major factors in many recent policy actions under Medicare. We hope that together we can participate in finding methods to address these issues in ways that do not disadvantage patients or cause unneeded and disruptive strain on the medical system itself.

Thank you.

STATEMENT OF N. THOMAS CONNALLY, M.D., CHAIRMAN, GOVERNMENTAL ACTIVITIES, AMERICAN SOCIETY OF INTERNAL MEDICINE, WASHINGTON, DC, ACCOMPANIED BY JOSEPH F. BOYLE, M.D., EXECUTIVE VICE PRESIDENT, ASIM

Dr. CONNALLY. Thank you, Mr. Chairman.

My name is Thomas Connally. I am an internist in private practice here in Washington and chairman of governmental activities for the American Society of Internal Medicine. With me is Joseph Boyle, M.D., who is executive vice president of ASIM. You have our entire statement. I would like to emphasize a few parts of that statement this morning.

ASIM believes that a reduction in the payment disparity between physicians' cognitive and procedural services will be the best thing to create proper incentives for cost-effective medical care. Although the term "cognitive services" is less than perfect, it has proven to be best for succinctly describing the processes of problem-solving, diagnostic evaluation, data collection and analysis, therapeutic assessment and case management, family and patient counseling, and, of primary importance, consistent, continuing, compassionate care for patients.

These services have always been paid, or certainly for the last decade have been paid, at lower rates than technical services. Physicians, finding that insurance programs traditionally have maximized coverage for procedures, with lesser coverage for cognitive services, have placed more emphasis on charging separately for laboratory tests, ancillary procedures, and other covered services. In marketing terms, the office visit became an unconscious loss leader.

This disparity continues. A study by the Health Care Financing Administration has found that cognitive services such as physician office visits are undervalued by a factor of between 2 or 3 to 1, as compared to diagnostic or surgical procedures. As a result, a physician who orders or performs an expensive array of technological services is well compensated. A physician who spends time with a patient, carefully assessing his or her need for further tests or procedures, is penalized for that style of practice.

Logic and research both tell us that reducing incentives to provide technology-intensive care will lead to fewer tests being ordered, fewer procedures being performed, and in all probability fewer hospitalizations.

In order to create proper incentives, we propose replacing the existing customary, prevailing, and reasonable charge system, which has been already distorted by fee freezes, payment lags, and other controls, with a prospectively developed schedule of allowances that would indemnify beneficiaries for services rendered by physicians. This schedule of allowances should be based on a relative-value scale based on resource costs. Once a resource-cost relative-value scale is developed, conversion factors can be applied. They can be based on budgetary and fiscal objectives, among other factors, to create a schedule of allowances. These conversion factors could be adjusted on a regional basis to reflect legitimate differences in the cost of practice in different parts of the country.

This alternative would be far more rational and predictable than the current system. Patients, for the first time, would be able to know in advance exactly what Medicare will pay, thus enabling them to select physicians whose actual charges are competitive with the schedule of allowances.

Physicians and patients could voluntarily choose to enter contracts to accept the Medicare schedule as full payment, or could voluntarily elect some other fee arrangement.

I have asked Dr. Boyle, our executive vice president, to share with you briefly his thoughts on how a relative-value scale can be developed.

Senator DURENBERGER. Joe.

Dr. BOYLE. Good morning, Senator, and Senator Boren.

The American Society of Internal Medicine supports the decision which was made recently by HCFA to contract with Harvard University to develop a resource cost-based relative-value study. This methodology, we believe, involves assessing the appropriate mix of time, complexity, investment in professional training and education, overhead, the cost of liability risks, and other appropriate resource elements.

We believe the involvement of the American Medical Association assures that this study will have acceptability by the medical profession.

We believe that, for the first time, it will provide a benchmark in determining which services are appropriately valued or not. Other proposals are less likely to address these disparities, much less to resolve them.

We believe that the resources that have been identified by Harvard are generally accepted within the profession as being valid indicators of the value of physician services.

The definition of complexity, for example, includes the elements that most speakers have addressed today—the necessary diagnostic skills, clinical judgment, and technical skills required to perform a service.

Including overhead costs assures that future adequate relative compensation will be provided. We believe that a project such as the Harvard proposal will provide a proper mix of both objective data obtained through surveys and other sources and the consensus development needed to develop a workable and acceptable RVS.

We will be pleased to respond to any questions.

Senator DURENBERGER. All right. Very good.

Dr. Jones.

[Dr. Connally's written testimony follows:]

TESTIMONY

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE

SENATE FINANCE COMMITTEE

ON

PAYMENT FOR PHYSICIAN SERVICES UNDER MEDICARE

DECEMBER 6, 1985

Introduction

My name is N. Thomas Connally, MD. I am an internist in private practice in Washington, D. C. and chairman of governmental activities for the American Society of Internal Medicine (ASIM). I appreciate the opportunity to express the views of internists throughout the country on alternative payment methods for physician services under the Medicare program.

In the years since ASIM was founded in 1956, the Society has played perhaps a leading role within the medical profession in studying and formulating innovative approaches to paying for physician services. During the past five years, in particular, the Society has devoted considerable time and resources to identifying the problems in the current system of payment for physician services--and developing constructive proposals to address and resolve those problems. Based on this tradition of innovation, ASIM has developed specific objectives and principles on payment for physician services, and is in the process of developing specific proposals that could serve as a basis for legislation to alter the current system of payment under the Medicare program. Although this is an ongoing endeavor, it will result in the development of additional proposals in the near future. I am pleased to share with you now the current state of ASIM's thinking on this subject.

Objectives of Payment Reform

In October 1985, ASIM's House of Delegates--a democratically-elected body of internist-leaders from throughout the country--met to consider ASIM's long-term

1 priorities and objectives on payment for physician services. The House of
2 Delegates adopted several important statements of priority and objectives that
3 are especially relevant to Congress' consideration of alternative payment
4 options. Those statements including the following:
5
6 1. Maintaining a pluralistic approach to the organization, delivery and
7 financing of medical care should continue to be of highest priority. A pluralistic
8 system will reserve the ability of patients, physicians, and third party payors to
9 participate and experiment with a wide variety of acceptable methods of payment
10 for physician services, including fee for service, capitation, salary, and fee
11 schedules. Under a true pluralistic system, the federal government should not
12 favor any particular method of organization, delivery, and financing of medical
13 care over another.
14
15 2. Improving reimbursement for physicians' cognitive services in
16 comparison to procedural services must be an essential objective of proposals to
17 change the system of payment for physician services.
18
19 3. Maintaining the rights of physicians and patients to voluntarily enter
20 into agreements, on a selective claim basis on whether or not assignment will be
21 accepted must be part of any proposals to change the system of payment under
22 Medicare. The individual assignment option clearly establishes that physicians
23 work for their patients, not for the government or other third party payors.
24 Further, the record shows that physicians have been sensitive to the financial
25 needs of their patients in exercising the flexibility permitted under the individual
26 assignment option, with the vast majority of physicians accepting assignment on
27 claims for services rendered to poorer, sicker, and older patients. Overall,

1 acceptance of assignment has increased to approximately 70% of all claims
2 according to HCFA statistics. For these reasons, ASIM continues to oppose
3 mandatory assignment or other proposals that would coerce physicians and
4 patients into involuntarily giving up their right to establish their own financial
5 arrangements.
6
7 The Society is aware of the concerns expressed by some beneficiary groups over
8 the lack of predictability of Medicare's current individual assignment option and
9 its potential adverse impact on low income beneficiaries. Although the Society
10 believes that the evidence clearly shows that the current assignment option in
11 general serves the interests of patients well, the Society is committed to
12 exploring ways to improve the predictability of the individual assignment option,
13 particularly as it relates to low income beneficiaries. The Society hopes to be
14 able to share with Congress some suggestions in this regard in the near future.
15
16 ASIM also believes that the minority of physicians, including those in internal
17 medicine, who charge excessive or exorbitant fees (i.e., fees in excess of any
18 reasonable standard of compensation based on the resources involved in providing
19 the service) or who increase their incomes by ordering services that are not
20 clearly medically appropriate provide a disservice to both patients and the
21 medical profession. ASIM intends to investigate legally acceptable mechanisms to
22 strengthen the ability of peer review groups to exert influence over those
23 physicians who charge excessive or exorbitant fees or who increase their incomes
24 by ordering medically inappropriate services, and urges other medical
25 organizations to do the same.

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1 As noted above, ASIM believes that reducing the disparity between physicians'
2 cognitive and procedural services must be an essential element of payment
3 reform. Because of the importance of this issue, I think it would be helpful to
4 elaborate on why it is essential that this problem be addressed in any legislation
5 enacted by Congress to change the current system of payment for services under
6 Medicare.
7
8 Reimbursement for Physicians' Cognitive and Procedural Services
9
10 ASIM believes that a reduction in the disparity between physicians' cognitive and
11 procedural services is necessary to create proper incentives for cost effective
12 medical care. Some have suggested that the term "cognitive services" may be less
13 than perfect. It has, however, proven to be the best term in our view for
14 succinctly describing the processes of problem solving; applying diagnostic skills
15 through comprehensive history and physical examination; data collection and
16 analysis; therapeutic assessment and case management; patient and family
17 counseling; and of primary importance--consistent, continuing compassionate care
18 for patients.
19
20 These "thinking and caring" services have always been paid for at lower rates than
21 technical services, and health insurance payment mechanisms have aggravated
22 this imbalance. Health insurance was originally created to protect patients from
23 the high cost of hospitalization and later from the cost of surgery. Benefits were
24 later expanded to cover procedural services, such as laboratory tests. Since
25 charges for cognitive services were not covered, they remained low so as not to
26 produce serious strain on the family budget. Physicians, finding that diagnostic
27 and therapeutic assessments were not covered, also began to place more emphasis

1 on charging separately for laboratory tests, ancillary procedures, and other
2 covered services. In marketing terms, the office visit became an unconscious
3 "loss leader." This disparity continues today: A 1979 study by the Health Care
4 Financing Administration (HCFA) found that cognitive services such as office
5 visits are undervalued by a factor between two and three to one compared to
6 surgical procedures.
7
8 Influenced by these factors, an irrational physician payment system has evolved
9 and is having a negative influence on the care Americans receive today.
10 Distortions in the relative valuations of cognitive and procedural services have
11 created financial disincentives and likely contribute to the public perception that
12 medicine today is too costly, inefficient and impersonal. Under the current
13 system, a physician who orders or performs an expensive array of technological
14 services is well compensated. A physician who spends time with a patient,
15 carefully assessing their need for further tests and procedures, is penalized for
16 that style of practice. Logic and research both tell us that reducing incentives to
17 provide technology intensive care will lead to fewer tests being ordered, fewer
18 procedures being performed, and in all probability, fewer instances of
19 hospitalization.
20
21 The importance of improving reimbursement for cognitive services in comparison
22 to procedures is supported by the vast majority of physicians in all specialties. In
23 1984, the House of Delegates of the American Medical Association (AMA),
24 following the lead of many state medical associations and specialty societies,
25 endorsed the principle that there must be a reduction in the disparity in
26 reimbursement between physicians' cognitive and procedural services. The
27 American Association of Retired Persons (AARP), representing a substantial

1 number of Medicare beneficiaries, also has come out strongly in favor of this
2 objective. The concept that improved reimbursement for cognitive services will
3 bring cost saving to the medical care system is also supported by a large and
4 growing body of research and expert opinion. ASIM will be pleased to share with
5 the Senate Finance Committee at a later date some of the research and expert
6 opinion that supports this conclusion.
7
8 Some have misinterpreted the cognitive services concept as an attack on the
9 incomes of physicians in certain specialties. This is not the case. A physician's
10 most essential resource is the ability to gather data, analyze it, synthesize it, and
11 formulate appropriate solutions. All physicians, regardless of specialty, use this
12 ability. For surgeons and others, compensation for this talent is built into the fee
13 for the procedure. ASIM believes simply that a similar measure of recognition for
14 the use of this talent is needed where no procedure or testing is involved. A
15 consultation by a well-trained surgeon that concludes surgery is not needed may
16 be worth more to the patient--and be less costly to the system--than one that
17 results in a surgical procedure. From our perspective, it makes no sense to
18 require a physician to perform a surgical or technological procedure in order to be
19 compensated for his or her cognitive services.
20
21 Unless the disparity in reimbursement between cognitive and procedural services
22 is corrected by future proposals to reform the system of payment for physician
23 services, the potential for cost savings and improved patient satisfaction may
24 prove to be illusory. For this reason, ASIM strongly urges Congress to carefully
25 analyze any policy proposals for changes in the Medicare system to determine

1 whether or not they are likely, on one hand, to create incentives for a less
2 technology intensive, more personalized form of medical care--or on the other
3 hand, whether or not they will simply perpetuate the distortions in the current
4 system.
5
6 Specific Policy Proposals
7
8 In order to create proper incentives under the Medicare system of payment for
9 physician services, ASIM specifically supports replacing the existing "customary,
10 prevailing, and reasonable" charge system (as distorted by fee freezes, lags in
11 payment, and other regulatory controls) with a prospectively developed schedule
12 of allowance that would indemnify beneficiaries for services rendered by
13 physicians. This schedule of allowances, in turn, should be based on a relative
14 value scale (RVS) based on resource costs.
15
16 Under this proposal, the Secretary of the Department of Health and Human
17 Services (DHHS) would contract with a research group to develop an RVS based on
18 resource costs. The recent decision by the Health Care Financing Administration
19 to award a contract to Harvard University to develop a resource based relative
20 value scale will provide the means for developing a concensus on more appropriate
21 relative values for physician services, based on the amount of time required to
22 provide the service; the complexity of the service; a physician's investment in
23 professional training and education; overhead factors, including the cost of
24 liability risks; and other appropriate resource factors that may be identified
25 through this study. It is our understanding that the American Medical Association
26 (AMA) will serve as a subcontractor for this important endeavor--thus insuring
27 direct input in evaluating relative values by physicians in all specialties.

1 This approach--unlike many other proposals to develop relative value scales--
2 should result in more appropriate emphasis being placed on complex, time
3 consuming cognitive services in comparison to procedural services. It would, for
4 the first time, provide a useful benchmark for determining which services are
5 undervalued, and which are overvalued, under the current system of payment. It
6 is our understanding that the Harvard project would use both consensus panels and
7 objective survey data in constructing the RVS--thus providing the right mix of
8 objective data and subjective consensus-making approaches needed to develop a
9 workable relative value scale. Because the American Medical Association would
10 be a subcontractor to this study, it is more likely than other proposals to meet one
11 important test of payment reform--acceptability to the medical profession. ASIM
12 believes that only the AMA, working with its constituent organizations, can lend
13 the imprimatur of acceptability to such a study.
14
15 The design of the Harvard study--particularly the role of the AMA in providing
16 input to the researchers-- also would help prevent the problems experienced by
17 the Massachusetts Rate Setting Commission when it implemented an experimental
18 resource cost based RVS for 25 procedures under its Medicaid and Workman's
19 Compensation programs. This produced a substantial increase in payment for
20 physician office visits, with the intent of narrowing the gap in compensation
21 between primary care and surgical and technological procedures. After the new
22 fee schedule was implemented, participation by internists, family physicians, and
23 pediatricians in the Medicaid and Workman's Compensation programs reportedly
24 increased. Many other physicians, however, expressed strong objections to the
25 reduced payment for some of their procedures, ultimately causing the Commission
26 to restore most of the cuts. The increased payment for office visits, however, has

1 been maintained. The unpopularity of the new fee schedule among some
2 Massachusetts physicians has led skeptics to conclude that the resource cost
3 approach is neither practical nor desirable. ASIM believes that the reaction to the
4 Rate Setting Commission's actions, however, had less to do with the validity of
5 the resource cost approach than with the manner in which it was implemented.
6 The Commission imposed major changes in reimbursement for physician services
7 without any direct involvement of physicians in determining appropriate resource
8 cost based relative values for those services. It is understandable and predictable
9 that many physicians who were denied the opportunity to participate in the
10 process have found it difficult to accept the results.
11
12 For this reason, ASIM strongly believes that all specialties of medicine must be
13 involved in developing any future relative value scales that might be adopted by a
14 third party payor for payment purposes. The Harvard study, by asking broadly
15 representative groups of physicians in all specialties to use consensus development
16 techniques to estimate the amount of time involved, complexity of the problem,
17 and the knowledge, skill, experience, and other costs that go into providing each
18 service, would assure the level of involvement and input by physicians that was
19 lacking in the Massachusetts experiment.
20
21 Once a resource based RVS is developed, it would be a fairly simply matter for the
22 Medicare program to determine appropriate conversion factors--based on
23 budgetary and fiscal objectives among other factors--for each service included in
24 the RVS. Those conversion factors appropriately could be adjusted on a regional
25 basis to reflect legitimate differences in costs of practice in different parts of the
26 country. Through this process, a schedule of allowances would be created that
27 would be far more rational and predictable than that which exists under the

1 current system. Patients who are Medicare beneficiaries for the first time would
2 be able to know in advance what Medicare allows for their services--thus enabling
3 them to select physicians whose actual charges are competitive with the schedule
4 of allowances. Physicians and patients could voluntarily choose to enter contracts
5 to accept Medicare's schedule as maximum payment for their services; or they
6 could voluntarily elect to engage in some other fee arrangement.
7
8 Although some details of this proposal may still need to be worked out, it holds
9 the greatest promise of creating proper incentives in the medical care system,
10 promoting price competition, and enhancing pluralism and patient choice. ASIM
11 strongly urges Congress to carefully consider this option in exploring proposals to
12 alter the current system of payment. The Society urges Congress to take care,
13 however, not to endorse other proposals for payment reform (including some other
14 relative value scale proposals) that may simply perpetuate the inequities in the
15 current system, particularly between physicians' cognitive and procedural
16 services.
17
18 Capitation and Other Payment Proposals
19
20 President Reagan's Cabinet Council on Domestic Policy reportedly has decided
21 that, in the long term, the Medicare program should move toward a system of
22 capitation to insurance carriers--and that, in the meantime, the existing
23 "customary, prevailing and reasonable" charge system should be maintained.
24 Although the report from the Administration was not available for review by ASIM
25 at the time the statement was prepared, the Society is strongly concerned if this
26 means further delay in making rational changes in the system of payment for
27 physician services under Medicare.

1 Maintaining the existing "customary, prevailing, and reasonable charge system"--
2 as presently distorted by fee freezes, delays in payment, and other regulatory
3 measures designed to reduce federal expenditures--clearly is unacceptable to most
4 physicians and patients. Moreover, preserving the status quo would allow no
5 opportunity to make progress on implementing a more rational system. Even if
6 capitation is determined, after further analysis, to be a desirable goal, ASIM
7 believes that for the foreseeable future a large number of Medicare beneficiaries
8 will continue to receive care under non-capitated settings. Therefore, it only
9 seems logical that effort to bring about fundamental reform under the existing
10 fee-for-service system must be pursued. Moreover, a relative value scale based
11 on resource costs is not inconsistent with a system of capitation. Such an RVS
12 could be employed in determining capitation levels to insurance carriers. It could
13 also be used within HMO systems to determine levels of payment to physicians.
14 For this reason, research into developing a resource based relative value scale
15 should be pursued, regardless of the ultimate policy decision on capitation.
16
17 Further, ASIM questions whether an exclusive system of capitation is workable
18 and desirable. Although capitation can and should be an option available to
19 patients who are Medicare beneficiaries, ASIM is concerned about any system that
20 would make it impossible for beneficiaries to elect voluntarily to receive care
21 under a non-capitated system. At the very least, considerably more research and
22 experience on the workability of capitation models for Medicare beneficiaries
23 clearly is needed.

The Society also remains strongly concerned about any proposal to include physicians under the prospective pricing system (PPS) for hospitals. Recent studies and reports suggest that PPS for hospitals has, in some instances, compromised the quality of care provided to patients who are Medicare beneficiaries. The Senate Special Committee on Aging, for example, recently expressed concern that some patients are being discharged prematurely due to the incentives created by PPS. Under the current system, physicians can protect their patients from inappropriate discharges and other cost-saving measures that may adversely affect their care. If, however, physicians are placed under the same economic incentives as hospitals, their ability to act as advocates for the interests of their patients would be severely compromised. This particularly would be the case if physicians were paid by or through the hospital--in essence placing the physician in the position as acting as an agent or employee of the hospital, rather than as an advocate of his or her patients.

Conclusion

In conclusion, ASIM urges Congress to carefully consider the option of converting the Medicare system into a schedule of allowances based on resource costs. Such a system will assure greater predictability for both physicians and patients; would begin creating proper incentives in the system by reducing the disparity between cognitive and procedural services; would allow input by physicians in all specialties, through the American Medical Association, in developing a more appropriate relativity for physician services; and would provide a useful methodology that could be applied even if Medicare ultimately moves towards a system of capitation for all physician services.

I will be pleased to try and answer any questions from the Committee.

STATEMENT OF EDITH IRBY JONES, M.D., PRESIDENT, NATIONAL MEDICAL ASSOCIATION, HOUSTON, TX

Dr. JONES. Thank you.

We appreciate the opportunity of relating our views to you this morning. I am Edith Irby Jones, president of the National Medical Association.

The National Medical Association was founded in 1895 out of the need to address a special segment of the population. That need still exists. We represent more than 13,500 physicians, predominantly black, who serve significantly the poor blacks and other inner-city minority persons.

We have served this population to a significant degree prior to Medicare in 1965, and we continue to serve, sometimes without pay, and frequently with inadequate pay. We, out of necessity, have developed an expertise in caring for poor patients with inadequate pay.

We know that there is a disparity in morbidity and early mortality between minorities and the majority race in America. We recognize that the quality of health care must be accessible to all at an affordable cost. We are especially concerned that the disproportionate providers of health care to the poor, elderly, and disabled be able to continue to do so with adequate compensation and with dignity for the provider and for the patient.

The effects of poverty are manifest in the health of people. Poor people are less healthy than those who are economically advantaged and, thus, our recommendations are made recognizing the burden of care for these patients, especially the poor, black, and other minorities.

I have with me Dr. Reed Tuckson, who is a member of the Council for Medical Legislation Affairs for the National Medical Association, and I am going to ask him if he will present the recommendations that we have for you.

Senator DURENBERGER. All right.

Dr. Tuckson, welcome.

Dr. TUCKSON. Thank you.

The NMA is well aware of the need for cost-containment. Our membership has, for many reasons, devoted itself to the health care needs of a special subsegment of the health care market. We feel it is our responsibility to advocate that, as we develop innovations in health care financing, that poor minority patients who are demonstrably burdened with severe, multiple, and chronic health problems not be unfairly impacted nor disincentives be erected for physicians to care for this subsegment of the market.

Specifically regarding No. 1, the fee freeze, our membership cannot afford an extension of the freeze. Medical equipment suppliers and liability insurance carriers are not concerned that our membership's practices are overwhelmingly comprised of poor people whose care is disproportionately financed by public health insurance. It seems unfair to continue the freeze as our expenses and overhead increase, especially when, because of sociological realities and philosophical commitment, NMA's physicians have a limited opportunity to bill their patients or to serve more lucrative market segments.

Regarding the diagnostic-related groups and their application to this issue, we are extremely concerned about the implications of that activity. We are particularly concerned about the inequities related to the aspects of severity-of-illness. Our patients are not average; they require higher intensity treatment, and it creates a disincentive to treat critically ill persons, and it creates a strong incentive to limit or severely reduce the quality of service.

Regarding the relative-value scales, we look at this with interest. We are well aware that a critical fault of the current CPR system is its bias toward procedures versus cognition. Complex patients who are relatively unsophisticated require time for problem-solving, counseling, and monitoring. Additionally, outpatients require preventive services, currently not reimbursed under the regular system.

This relative-value scale will have the potential to remove the inequities in payment rates, and we await with interest the results of the studies ongoing.

Regarding the capitation and voucher systems, this also may have merit, especially in its freedom-of-choice aspects. We caution, however, that the rate must be adequate and the implementation system flexible enough to provide both for, No. 1, incentives for private sector insurers to offer the necessary comprehensive services, for which the voucher allowance would compensate, and would do so in a quality manner; and, No. 2, consideration must be given to catastrophic events that may be beyond the limits of the voucher policy.

In conclusion, we sincerely hope that, as we consider alternative financing mechanisms, we will do so in a thoughtful and compassionate manner, and that this country will continue to appreciate the need for enhancing access to quality care for all Americans.

Thank you for the opportunity.

Senator DURENBERGER. Thank you very much.

[Dr. Jones' written testimony follows:]

TESTIMONY

OF

DR. EDITH IRBY JONES
PRESIDENT
NATIONAL MEDICAL ASSOCIATION

BEFORE THE

SENATE COMMITTEEE ON FINANCE
SUBCOMMITTEE ON HEALTH

SENATOR DAVID DURENBERGER,
SUBCOMMITTEE CHAIRMAN

DECEMBER 6, 1985

Mr. Chairman and members of the committee, I am pleased to have the opportunity to testify on behalf of the National Medical Association on the issue of changes in the reimbursement systems under Medicare (part B) payments to physicians. The National Medical Association, founded in 1895, now represents over 13,500 minority physicians nationwide and has as its major objectives to improve both the overall status of minority medical practitioners as well as the quality of health care for all patients.

At present, the Department of Health and Human Services is attempting to reduce the cost of medical services, particularly Medicare payments to physicians. It has been indicated that Medicare payments for physician services have grown more rapidly than payments for hospital services. Therefore, proposals have been developed to refine a system that would allow more predictability of physician payments and reduce their rate of growth.

The present system for paying physicians under Medicare, a customary-prevailing-reasonable basis system (CPR), has been criticized for being "inflationary". This system has also been criticized for built-in incentives for physicians to provide more than the average number of services. Therefore, a reformulated Medicare payment system and alternative medical practice modes are being considered; the arguable objective of these mechanisms are to encourage physicians to become more efficient and to allow the federal government to anticipate the costs of physician services under Medicare.

The National Medical Association is aware of several of these proposals. They focus around several issues which include:

1. changing physician practice modes with respect to group practice arrangements to financially encourage physicians to provide fewer services,

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2. changing the units of services that are reimbursed under Medicare. This encompasses collapsing particular services into packages or groupings of services and paying for these services in this respect. For example, services might be grouped under particular diagnoses or into comprehensive groupings.

The National Medical Association is extremely concerned about the impact of any prospective payment method on a physician's ability to provide quality health care to each one of his/her patients. We are particularly concerned about the potential impact of any prospective payment system on the ability to provide quality care to low-income populations. We believe that any type of prospective payment system, as we understand it, would have an adverse effect on the health status of minorities and their ability to receive health care.

NMA physicians provide medical care largely to limited income, urban, Black populations. One serious problem with the present DRG system is it does not include a fair consideration for the intensity of treatment so often required by low-income patients. It is not unreasonable to expect that the economic behavior of individual physicians as owners/managers of health care delivery entities to be similar to that of hospitals: to survive as business entities physicians as well as hospitals must reduce as much as possible the financial risks associated with the delivery of health care services. If a compensation system does not provide a fair return for services required to meet the health care needs of particular patients, the compensation must increase or over time, services will be reduced or refused altogether. Under a DRG type formula for prospective payments, how can a physician afford to

maintain a practice which serves an above average number of severely ill patients. These factors must be considered in any objective critique of the impact of any prospective system on a physician's ability to provide quality health care.

Aside from the damaging impact on quality care for the severely ill a DRG like system--wherein prospective payments are constructed on averages--will negatively affect the geographic distribution of doctors. Moreover, a DRG type prospective system is likely to alter physician approaches to providing important counseling services with patients with certain potentially high mortality diseases.

To predict the possible impact on these patients it is necessary to examine the experiences of the hospital industry with respect to the introduction of Diagnosis Related Groups prospective payment system (DRGs) in 1983.

SEVERITY OF ILLNESS

As stated, an important criticism of the prospective payment system (DRGs) is that severity of illness and complexity of illness is not incorporated into this payment mechanism. By severity we are referring to the intensity of an illness, whether the patient's problem is mild or severe. By complexity, we are referring to a patient with multiple illnesses that would complicate a primary health problem, for example, a hypertensive patient may also have diabetes. Under this system, payment for services are based on an average. Under a DRG like system payments to physicians who are required to serve an above average number of severely ill patients will not meet the costs

of providing them health care services. A DRG type payment system for physician services would mean that reimbursement rates would be identical for physicians that care for the severely ill patients as well as those that care for the less severely ill. In essence these physicians would be penalized for treating a "sicker" population.

This is particularly crucial with respect to physicians who serve a large proportion of low-income, elderly, minority patients. For several reasons Black patients tend to defer seeking care until their illness has reached a severe stage. Eventually such patients will become overly burdensome to physicians whose Medicare reimbursements are not covering the total cost of services required for his/her patient population.

Inherent in the DRG prospective payment system, then, is the incentive to "attract" and treat patients with less severe illnesses.

Alternatively, physicians will be pressured to provide minimal care. The physician is faced with the option of choosing between a higher and lower cost procedure for the same illness. This would imply that the DRG type of payment system is not economically neutral in its impact on the provision of quality care for the severely ill. The economic impact of a DRG type prospective payment system for physicians would further exacerbate the already present two-tiered health care system: a total access system for the wealthy and at best one of more limited access for the poor.

GEOGRAPHIC DISTRIBUTION

Neither would such a payment system be neutral in its impact on a physician's choice of practice location. Under a similar system to hospital DRGs, physicians would be more inclined to establish their practices in areas

with "healthy" patient populations. This would result in a greater shortage of physicians in predominately Black, low-income communities. Young physicians, especially, would not have a large enough financial base to practice in those areas where, due to a "sicker" population, payments for services would be too low to cover physician expenses, which usually include significant costs for loans associated with their medical education.

COUNSELING AND MANAGEMENT

Consideration must also be given to the impact of "average" costs of prospective payment systems on diseases that require extensive patient counseling and management services. These include illnesses such as hypertension and diabetes that require periodic monitoring. If the cost of the physician time is not valued in this payment system, the incentive will be for physicians to provide less consultative services for such chronic illnesses. This point is critical with respect to minority patients who exhibit higher rates of hypertension, cardiovascular disease and diabetes than the majority population. There would be little incentive to provide ongoing disease management services to these patients and this would have serious implications for the successful treatment of these diseases.

SUMMARY

The National Medical Association is concerned about the impact of a prospective payment system on physicians in that such a system has built-in incentives to encourage the treatment of patients with less severe and less complicated diseases. We believe that our particular patient population,

mainly the urban, poor, minority population, will ultimately be viewed by many physicians as financial risks. Therefore, they will be excluded from receiving the necessary health care, due to their need for more costly services.

We are also concerned that young physicians will be unwilling to establish practices in low-income minority communities where patients have illnesses that are more severe than the average population and therefore more costly.

RECOMMENDATIONS

1. The NMA encourages your Committee to examine methods of ensuring an equitable payment system that would not permit a segment of the population to be viewed as a financial risk to physicians. Therefore, severity of illness and complexity of illness measures must be an essential component of the proposed payment system.

2. We also suggest that a measure or valuation of physician time with respect to patient management and counseling for chronic illnesses be incorporated in a mechanism for determining physician fees.

3. The NMA is in favor of a system for determining physicians' fees that is based on a relative value scale. This scale, in essence, would assign a weight to each procedure and a multiplier to convert that weight to a dollar value. The advantage of this method is that the multiplier can be adjusted for inflation and local cost of living differences. Also, a relative value scale can be applied to payments for outpatient as well as inpatient physician services.

The NMA believes that any payment system under Medicare that is considered would need to place more emphasis on the delivery of quality care, while ensuring that physicians do not assume undue financial risks for delivering that care.

Senator DURENBERGER. Let me begin right at that point and ask each of you—in some cases it is a reiteration—to scope out the reality of most health care services or acute health care services. I mean, we have been reminded by Dr. Connally, of course, of our concerns for the cognitive. We are reminded by Dr. Tuckson that, when a lot of people come into a doctor's office with an ache or a pain, there is a lot more complicated health care concern on the part of the doctor than just that precise ache or pain; there is a larger environmental setting that good physicians need to take into consideration.

So, beyond the procedural, as Dr. Connally calls it, or doing it by the numbers, I take it in trying to put together a professional reimbursement system we need to take a lot of other things into consideration. And the various approaches to this that were suggested by our previous panel, I imagine, have various merits and demerits regarding the cognitive and some of the other aspects.

So, I wonder if each of you wouldn't suggest to us that there is a larger picture than the set of procedural steps that need to be taken, and suggest to us how you think one or the other of these—RVS versus some other system—might be better as a formula than the alternatives.

We will start with Dr. Davis.

Dr. DAVIS. Thank you, Mr. Chairman.

Yes, sir, I think we do have some problems, many of us, with the procedural versus cognitive definitions. Dr. Utz and I are both surgeons. We do a great deal of procedures. But some of our most important work is cognitive work, because surgeons do cognitive work, and the term really is not very clear.

To answer your question directly, the American Medical Association does strongly endorse a resource-based relative-value scale. And, as has been outlined to you today, that is based on many factors, including the time involved, the complexity of the procedure or of the problem at hand, investment that has been made in the education of the practitioner, overhead involved, and the expense to provide professional liability protection.

Even the surgeons among us recognize the fact, that the cognitive aspects of practice have perhaps been underpaid, and perhaps it should be put back in a more relative position. And we think that a resource-based relative-value scale would do that.

Senator DURENBERGER. Dave.

Dr. UTZ. Thank you, Mr. Chairman.

It is difficult for a surgeon to define the term "cognitive." If it means that surgery does not involve cognitive activity, that is obviously not the case. Surgery also involves a feeling of humanism and of identification with the patient, with his illness, with his family, with his community in the pre-operative care, and in the analysis of a patient's problems, as it does in the operating room and after the surgical procedure, in post-operative visits.

So, nonprocedural—which is a better word—and procedural activities are those that encompass the activity of a surgeon. Nonprocedural and procedural activities also involve internists and general practitioners, family practitioners, as they do diagnostic tests, as they prescribe medicine, as they may order some complex diagnostic procedures.

I think surgical strategy of combining or bundling the services into a pre-operative, operative, and post-operative package is a desirable one, and it can be emulated by those who charge for each office visit.

Mr. Chairman, regarding which payment alternative would be best as far as surgery is concerned or the medical practice as a whole, I might observe that medicine has developed recognizing several pathways to care. And acceptance of any alternative plan without a careful consideration or trial, specifically regarding its impact on access to care for the elderly and its definition of quality of care, I think will destroy what we have accomplished to date and will impede any future developments in this area.

Thank you, Mr. Chairman.

Senator DURENBERGER. Before I ask the two of you to respond, I don't know how we are going to do this, but if you all want to sit here while we go over and vote, you are welcome to do it. I would excuse the panel, too, if you want to go to lunch, but we have to go over and vote here in about a minute and a half.

If you are not going to be able to come back, do you have a question, Senator Boren.

Senator BOREN. Let me ask a very quick question. They indicated yesterday in our meeting that they will not hold rollcalls past a certain time.

I would like to address this to Dr. Utz in particular:

One of the strengths that I think we have in our system is the diversity that we have had, the fact that we have developed centers of excellence such as your own clinic. The Mayo Clinic is an example of that center-of-excellence approach. I wonder what you believe that the major changes in physician reimbursement, particularly any move toward capitation for example, might have on the development of maintaining these centers-of-excellence or future development of centers-of-excellence like that?

Dr. UTZ. Thank you, Senator Boren.

As far as capitation is concerned, and institutions or private practitioners who maintain an excellent quality of practice, I think there are some concerns. There are some disadvantages. A capitation system, while it has worked fairly well in the Twin Cities—and there may be some argument about that—has not done as well or performed as well in rural Minnesota.

A single identifiable unit to take care of a particular patient population, so that the individual has no opportunity to select his physician or perhaps to affect the amount of care that he receives, can be a disadvantage of capitation.

Capitation does offer some advantages. It would take the government out of health care administration to a certain extent, it would properly emphasize preventive care, preventive medicine, and it would probably reduce revisits, and readmissions.

But what concerns me about capitation is the risk of reduction of access to necessary medical services and compromise in quality of care.

Senator BOREN. Senator Durenberger and I apologize that we are caught in this situation. Senator Durenberger asked that we go ahead and excuse the panel because of the time constraints that we are under. If any of you would like to submit any additional sup-

plements to your statements, please feel free to do that, and we will have them included in the record.

He will be returning, and the representative of Blue Cross/Blue Shield will present his statement just as soon as we get back from this vote.

Again, we apologize for the situation in which we find ourselves. I know that members of this panel understand that as well as anyone, on the kinds of disruptions that occur.

Thank you very much.

[Whereupon, at 11:59 a.m., the hearing was recessed.]

AFTER RECESS

Senator DURENBERGER. The hearing will come back to order. Our final witness is Bernard Tresnowski, president of Blue Cross and Blue Shield Association of Chicago, IL.

Bernie, your full statement will be made part of the record, and you may proceed to treat it in any way you like, depending on what time you have to get to lunch.

STATEMENT OF BERNARD TRESNOWSKI, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, CHICAGO, IL, ACCOMPANIED BY LARRY MORRIS, SENIOR VICE PRESIDENT, HEALTH BENEFITS MANAGEMENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. TRESNOWSKI. Thank you very much, Mr. Chairman.

Joining me this morning is Larry Morris, who is the senior vice president of health benefits management for the association. Larry is our resident expert on physician payment; he spent almost his entire professional career worrying about that subject.

You have our testimony and, as you said, it will be in the record. It does several things: It establishes our credentials for discussing physician payment. I would simply add to what is in that statement that last year we paid out $8 billion in physician payments under our private programs and were responsible for the administration of another $10 billion under our carrier responsibilities under Medicare.

The statement also reviews our experience with physician payment systems in our private programs. I know that is a special interest of this committee. It presents our views of the advantages and disadvantages of Medicare's current physician payment system and concludes that it is time to proceed with payment reform.

We present a set of criteria against which possible reforms should be tested; we review a series of possible reforms ranging from all the things you have heard this morning—capitation systems, per-case fee schedules, per-procedure fee schedules, reasonable modifications to the existing, customary, prevailing, and reasonable payment system under Medicare.

We note specifically in our statement the importance of selecting a payment system that relates directly to the level of assignment and the close correlation between payment and that assignment level in order to assure predictability and full financing on the part of the beneficiary.

We also note the importance of controlling the use of services, because use is the principal determinant of cost—it is not price—and any payment system that doesn't take both into account is flawed.

With that by way of background, in terms of the statement, let me proceed and tell you what we believe, and let me put it in the framework of a question you asked this morning: Do we do one thing at a time? Or do we move on parallel paths? And let me tell you what we believe in that context.

First of all, we believe that Medicare should move aggressively to a capitation payment system, as has been explained this morning. They ought to exploit the HMO and the comprehensive medical plan opportunity that is now available.

In addition, we urge that experiments in geographic capitation be pursued without delay. There is a proposal from the Maryland Blue Cross and Blue Shield plan that has been on the table in HCFA now for several months waiting for a decision, and we think a decision ought to be made on that and tested, to find out whether indeed it makes sense.

Senator DURENBERGER. Can I stop you at that point and say, are there conditions on that proposal, like "we don't want any competition," or "we want to be the only one in town"?

Mr. TRESNOWSKI. No; the proposal is such that existing HMO's and CMP's would not be a part of the capitation, but that the remaining portion of the population would be covered under a single carrier.

That is an experiment. If you were to go into a competitive situation where you would want to broaden geographic capitation, then you do it on a competitive-bid basis, let any carrier come in and say, "Given a certain population base"—whether it be a county or a State or whatever—"let's bid on it," the same thing we do with major accounts.

Senator DURENBERGER. Is it possible now for anyone to compete with Blue Cross and Blue Shield in Maryland?

Mr. TRESNOWSKI. Oh, I think so. They certainly do.

Senator DURENBERGER. What if some other Blue Cross and Blue Shield tried to come in and compete, and they couldn't get in? Isn't that in the back of my head someplace?

Mr. TRESNOWSKI. Do you mean could another Blue Cross and Blue Shield come in and compete?

Senator DURENBERGER. Yes.

Mr. TRESNOWSKI. No, they can't, not under our licensing arrangements with regards to the name and mark.

Senator DURENBERGER. But do you think in the State of Maryland there are competitive health plans with enough enrollment and enough marketplace penetration that they could take on Blue Cross and Blue Shield?

Mr. TRESNOWSKI. Well, I think the question really is to the degree of risk involved. I think the estimate is there is a billion-dollar risk under Medicare in Maryland, and the question is, does the carrier have the capacity to take on that size of a risk. But frankly, Blue Cross/Blue Shield of Maryland doesn't have the capacity to take on that risk, and the arrangement that is in HCFA

at the moment is to take a portion of that risk and to reinsure the balance of it.

Any carrier, regardless of size, could put together a set of reinsurers to take on any amount of risk it wanted, depending upon whether it wanted to take on the administrative challenge.

I point to Maryland not so much as an example of what ought to be done in terms of an operational situation, but I point to it only because we need some experience with geographic capitation, and there is an opportunity to find out some things about it.

Senator DURENBERGER. Yes; I didn't interrupt you to be disruptive but for the same reason I interrupted Henry in his presentation, because, these demonstrations are a way to, in effect, establish—I used the Gold Plus in Florida—a big part of the market.

I guess what I am searching for here is some ideas on how to do demonstrations that ensure that they aren't going to be anticompetitive. If HCFA gave a demonstration on physician reimbursement, capitation, to Blue Cross in Maryland, and Blue Cross in Maryland already has 85 percent of the business, and all this does is prove that they can reduce costs, it also puts them in the saddle against anybody who tried to come in in the future and sell either combination plans or physician plans against them, it seems to me.

Mr. TRESNOWSKI. Well, then I think what you need to do in Maryland, specifically, under a demonstration is to solicit other people to come in and offer a proposal to do a similar thing. I think there are a lot of carriers out there with the capacity to take on a billion-dollar risk with proper reinsurance opportunities.

I think the critical question isn't so much whether you can structure a competitive arrangement, it is a question of whether anybody wants to take it on. And it isn't always the risk involved, it is the administrative complexity of what is being asked for.

Senator DURENBERGER. All right.

Mr. TRESNOWSKI. And in that case I think the reason we would urge that capitation be pursued is because it offers the greatest advantage of the criteria we laid out in the testimony: simplicity, predictability, efficiency, and financial protection.

The utilization point that we made in our testimony is covered under a capitation arrangement. It strikes at the critical balance between money and medicine, and it pushes the decisions down where they belong, and that is at the time of the medical transaction. I think that is the real advantage of it.

But you are not going to get total capitation arrangements around the country; and, short of that, we look to the many conceptual advantages in a per-case fee schedule, using a system similar to DRGs.

Now, unfortunately there are some very significant feasibility problems involved in that kind of reform. Our suggestion is that, even though there are those feasibility issues, that, as some of the witnesses said this morning, that ought to be pursued. I wouldn't give up on that.

You personally made a suggestion some months ago about putting together a per-case arrangement covering the whole spell of illness, from the physician's office to the hospital and the skilled nursing facility, the hospice, and so on. I think, conceptually, that continues to make an awful lot of sense; the question is, how do

you technically design such a system, and who manages that per-case payment amount? But it does make an awful lot of sense, and I think it needs to be explored and pursued aggressively.

With that in mind, we would therefore, in the context of pursuing reimbursement reform, recommend a three-part strategy for payment reform:

First, that Medicare move to a per-procedure fee schedule. And I realize that there are problems in that transition—resource-based relative-value schedules, consensus relative values, and so on. We think that a resource-base is fine and it ought to be pursued, but I wouldn't wait around for that to perfect itself; I would move it out of the area of academics and put it into the area of operations. Consensus building we do all the time on the basis of all sorts of profile information; you just throw it up on the screen, get a group of guys in the room and say, "What do you think?" And then you start paying that way.

Senator DURENBERGER. All right; that is why you are on this hearing today, because between the two of you you have all the experience in doing this sort of thing. And is it relatively—the consensus model? It is not a difficult model to follow?

Mr. TRESNOWSKI. No; And you are using judgment. Nothing is perfect, and so you take the profiles drawn from your chart information, look at the inequities that are built in, and some of them are quite obvious. You get a group of people around a table, and in a couple of hours they have sorted it all out.

There will always be those who will say, "Well, you didn't do this, and that, and the other thing"; but you have done a reasonable justice, and then you are going to start paying that way. And we would urge that that be done.

The second part of the strategy is, we think the assignment question has to be dealt with. And as we have said many times before, we think an all-or-none policy is critical, that at one point in the year a doctor ought to be asked whether he is going to take assignment and stay with that during the course of the year. We think that is extremely important in terms of understanding and predictability, especially when you have got a fee schedule arrangement.

With a fee schedule, where the amounts are known, and an all-or-none policy, you have greatly simplified the payment program for the beneficiary, and I think that is an important criterion to be kept in mind.

The third part of the strategy deals with the utilization-review question, recognizing that you don't have a capitation arrangement where you have got those incentives turned around. Then what I think you need to do is to further strengthen the utilization-review and medical-review capacities of the carriers.

We think we have done a good job with that. We wish we had more money from the administration to be able to pursue some things; but there is a lot of capacity out there among the carriers to do a good job, and we would urge that the existing system be strengthened.

Now, we understand that making a move to the three-part strategy I've outlined doesn't happen overnight, and therefore we think that there are some short-term things that ought to be done right now with the existing Medicare payment system. And quite frank-

ly, the most immediate thing that we would do is to take the CPR system, the so-called customary, prevailing, and reasonable Medicare system, array it, get a group of people in a room and build a consensus about some of the extremes—high and low—and give some authority to the carriers to do the same kind of thing and get on with it.

Senator DURENBERGER. Have you done that already in parts of the country?

Mr. TRESNOWSKI. We do it all over, all the time. We have a lot of physicians who work for us. We have worked with panels of doctors drawn from the medical community.

Let me give you an illustration of this. A comment was made this morning when Senator Heinz was here about Pennsylvania. The assignment rate in Pennsylvania is up over 90 percent, and one would say, "Why is that?" Well, why that is is that there is a tremendous spillovers from the private sector acitivities of the Blue Shield plan of Pennsylvania, which has a high percent of participating physicians. Why are there a high percent of participating physicians? Because there is a lot of involvement along the lines I talked about, in terms of consensus building and what constitutes a perfect fee distribution.

You have to understand that involving the medical profession at the community level is critical. That doesn't mean you give the house away; but you use them in order to fashion a system that has, as I say, a certain amount of justice built into it for everybody concerned. That's it. That is the sequence we would recommend. Do something right now with the existing system, move to that three-part strategy I talked about, and pursue capitation aggressively.

Senator DURENBERGER. Why don't we just take that previous panel—Janet Mitchell, on down through the rest of them—and put them together with you? Wouldn't we all come with something?

Mr. TRESNOWSKI. You could do it in a day. And the problem is that everybody studies the subject to death. I think what you need to do is put them in the context of paying, against the criteria of what you are trying to accomplish. And then just put their feet to the fire and get the job done, aod then start paying that way.

Senator DURENBERGER. I take it one of the concerns on the part of some of the medical specialties in particular would be that, "Yeah, we would put everybody together in a room, and we would put a system together, and we would say, 'We will give you so much for procedural and so much for nonprocedural.' " And a year later we would start ratcheting down. You know, we would just start cranking it down; because it is so informal that nobody can rely on it. And good old Congress, with their Gramm-Rudman and so forth, would start the old winch going, first on the nonprocedural side and eventually raise questions about, "Ah, you can do it for a lot less than that even on the procedural side." Might that be one of the concerns that the professions would have about a process that would appear to be so unstructured or informal?

I will agree with you, however, that it is very realistic. I like your approach. But wouldn't that be one of the problems with it?

Mr. TRESNOWSKI. Sure, but let me explain it this way: If you convene them in a room, you are dealing with internal equity, and that is what they are focusing on. You are not talking about the

conversion factor—in other words, how much you are going to pay—you are talking about internal equity. And I am talking about all of them, and I listened to all of them this morning.

Senator DURENBERGER. As between the various forms?

Mr. TRESNOWSKI. As between cognitive, procedural, this, that and the other thing.

So I think they would all be willing to sit around a table and deal with that. They would also be willing to deal with some of the extremes. An example is cataract surgery. They are charging today as much for cataract surgery as some years ago when they put you in a hospital for 10 days in sandbags. Now they do it on an outpatient basis overnight; but the charge is the same. So, you have got those extremes. If you put them in a room, you can kind of iron all of that out. But that is internal equity, and everybody would agree to that.

The conversion factor—how much you pay for that, given the propensity of the Congress to rachet down—you deal with because of the assignment situation, the all-or-none. If you are interested, if the Congress is interested, in full payment to the beneficiary, then you really don't want to ratchet the number down so far that even the docs who want to stay with you are going to fall off the trolley because they can't afford to just take the Medicare payment. I think you made the point this ~~morning:~~ You have got to look behind it at what it costs the doctor to do his job. Even the guys who would like to stick around will say, "I just can't afford it anymore; I am not going to be able to take assignments."

Senator DURENBERGER. All right. So, if I follow this now, if I was concerned about having the right mix of specialties, that will be taken care of in that first informal phase? I don't have to worry about pricing certain people or underpricing certain people out of the market?

Mr. TRESNOWSKI. Right.

Senator DUREBERGER. When you get to the second phase, though, you start dealing with such things as geographic differentials, urban-rural, and some of those kinds of issues. Is it appropriate for us to look at those kinds of issues? And how do we approach that?

Mr. TRESNOWSKI. Absolutely. I think you have to. I think it clearly costs a physician more to deal in one geographic area than in another, and I think the same kind of consensus building has to go on there. It is a little different and maybe less of a technical-medical consideration than it is variations in cost-of-living, inflation factors, and that sort of thing.

Keep in mind that you are always going to be a little bit arbitrary in these situations.

Senator DURENBERGER. But I am wondering what the premise is on which we get to that phase. I don't have any of this before me, but a day or two ago I sat with the principal researchers from OTA who are doing the OTA report on this same subject, and they were telling me—you should know this, I suppose, as an intermediary—that the differences from one State to another are almost by a factor of two in terms of both the charges by some physicians for some services and the average dollar utilization by Medicare beneficiaries. And that is quite disparate.

I have the figures somewhere here in my opening remarks, or somewhere, that says that Manhattan is 100 percent higher than Minnesota, or the Twin Cities, for some kinds of surgery. Now, that is ridiculous.

Mr. TRESNOWSKI. Yes.

Senator DURENBERGER. But are we stuck with that kind of an historic base as we move?

Mr. TRESNOWSKI. You have two things there. You have, one, the price, the variation in the price. And then you have the variation in the total cost, which is a function of the variation in practice patterns.

In terms of price, I think you have to take some things into account in terms of the cost of living. Now, whether it is a factor of two to one between New York and the Twin Cities I don't know, but you can make a judgment on that.

The real problem, though, isn't price as much as it is variations in practice, and that is the one that everybody is most concerned about: "Why does it cost so much more? Why is the length of stay so different? Why are these intensity-of-care levels different on a similar diagnosis?"

Senator DURENBERGER. The utilization problem?

Mr. TRESNOWSKI. Yes.

Senator DURENBERGER. In using too many?

Mr. TRESNOWSKI. Yes.

Now, I suppose the expert on that is the group in Boston, and they weren't here today—although most of them were here today—that have looked at a small area of variations in New England, the Phil Caper and the so-called Wennberg Studies.

I have talked to Jack Wennberg, and what he says is, if you have a range of practice on a particular condition that is this far apart, that on those extremes they are clearly not explainable; but you go down here, and they are perfectly justifiable based upon the fact that medicine isn't scientific, that it is as much of an art as anything, and there are particularly legitimate considerations to be taken into account.

I think the PRO's would be well advised to look at those area variations. I know we are looking at them aggressively, because when we make the judgment, geography-to-geography, we are less concerned about the differential in price. That is more quantified in terms of economic indices. But variations in practices is not and needs to be considered.

Senator DURENBERGER. And your suggestion there is that the best approach to that issue really is doing good medical-utilization review?

Mr. TRESNOWSKI. That is right.

Senator DURENBERGER. Rather than trying to capture that always in the payment system?

Mr. TRESNOWSKI. That is right.

Senator DURENBERGER. A suggestion was made here earlier today that we might want to consider, as we approach physician reimbursement, incorporating the industrial side of this, or the hospital side of this, the pathologists, anesthesiologists and radiologists, and so forth—the folks in the surgical suite. Why not just incorporate that right into the hospital DRG and do everything else either the

way you are suggesting or some other way? Is that appropriate for us to continue to explore, or not?

Mr. TRESNOWSKI. Well, you know, we went through a phase, and I think we are still going through it, of debundling all those hospital-based specialists. We have always felt that was a little unfortunate, and I think it would be wise to pull them back together again.

Larry has spent some time worrying about that subject and maybe he would like to talk to you about it.

Mr. MORRIS. Well, it is an appealing thing to do conceptually; the thought that the patient does not have a choice between specialists of that kind, and that therefore the competition inherent in fee-for-service doesn't work——

Senator DURENBERGER. But the health plan itself? I mean, do you have much of a choice?

Mr. MORRIS. I'm sorry.

Senator DURENBERGER. Well, the argument has been made that the patient has no choice.

Mr. MORRIS. Yes, and I think that is true.

Senator DURENBERGER. Then is it true that the health plan doesn't have much choice, either?

Mr. MORRIS. Oh, yes.

Senator DURENBERGER. I mean, the referring physician is going to make his or her selection.

Mr. MORRIS. Absolutely.

Mr. TRESNOWSKI. You have an anesthesiology group working in a hospital, and you have a radiology group working. You don't have a lot of——

Senator DURENBERGER. Yes. All right.

Mr. MORRIS. So, you come to the basic question: Where is fee for service appropriate and where is it not appropriate? I think a lot less strong case can be made for it, you know, where "the patient has no choice, and the health plan has no choice, and there is no incentive to compete on price" than it can be in the other situation where price clearly is a factor in making a choice.

As someone pointed out on the panel, there are some problems inherent in that. I think it is going to take some work before we would be willing to make a final recommendation; but the basic idea is certainly worth exploring.

Senator DURENBERGER. Is there anything else we ought to touch on? The hour is getting late.

I put a question mark next to a comment here in your testimony relative to changes in the PRO law, that "we ought to remove the disadvantage carriers now face when bidding for PRO contracts." I thought I put that in there deliberately. As we said; when we said "peer review," we want peer review. Now, tell me I am wrong. I mean, don't tell me I'm wrong.

Mr. TRESNOWSKI. I am not going to tell you you are wrong; I think you are absolutely right, except in terms of emphasis. We have a lot of physicians who work for us and they work very——

Senator DURENBERGER. All right; you are just saying the entity—don't fire the entity as long as it is otherwise qualified to do the peer review with peers.

Mr. TRESNOWSKI. That is right, particularly if it is more qualified.

Senator DURENBERGER. And apparently would put you, for example, or any carrier at a disadvantage automatically, even though you might have as many doctors?

Mr. TRESNOWSKI. That is right. If there is a medical group that is able and ready to go, they get preference.

Now, we do have a couple of plans that are functioning as PRO's, because they couldn't find any alternative. And our knowledge is that they are doing well.

Senator DURENBERGER. All right. Thank you very much, Barney, and I thank everyone.

Mr. TRESNOWSKI. Thank you.

Senator DURENBERGER. That is the end of the hearing.

[Mr. Tresnowski's written testimony follows, as well as testimony of Franklin B. McKechnie, M.D., president of the American Society of Anesthesiologists:]

TESTIMONY

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

MEDICARE PHYSICIAN PAYMENT REFORM

BEFORE THE SENATE FINANCE

SUBCOMMITTEE ON HEALTH

BERNARD R. TRESNOWSKI

PRESIDENT

DECEMBER 6, 1985

Mr. Chairman and Members of the Subcommittee, I am Bernard R. Tresnowski, President of the Blue Cross and Blue Shield Association, the national coördinating organization for all the Blue Cross and Blue Shield Plans. Our member Plans have been managing health care benefits and designing and administering various payment arrangements with physicians, hospitals and other providers of health care for over 50 years. Today in the private health insurance market Blue Cross and Blue Shield Plans underwrite and administer health care benefit plans for 78 million subscribers. Under contracts with the Health Care Financing Administration, our Plans serve as Medicare fiscal intermediaries and carriers, responsible for day-to-day administration of this important program.

On behalf of our member Plans, I thank you for the opportunity to contribute to your review of possible reforms of Medicare physician payment. Clearly, any changes in the method of reimbursing physicians should be tested against several specific objectives. But before discussing these objectives and our recommendations, as background we would like to discuss briefly the physician payment approaches used by Blue Cross and Blue Shield Plans for the private market and Medicare's current method of paying physicians.

BLUE CROSS AND BLUE SHIELD PLAN PHYSICIAN PAYMENT APPROACHES

Blue Cross and Blue Shield Plans use a variety of methods to pay for physicians' services in the private market. Most of these methods are based on the UCR, or usual, customary, and reasonable charge concept. In 1984 about 80% of Blue Cross and Blue Shield Plan payments for physicians' services were determined under UCR-type systems. The remaining 20 percent of Plan physician payments were made on the basis of fee schedules. Most Plans administer both types of payment programs to accommodate the different types of benefit plans demanded by our customers.

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The UCR concept involves limiting payment to the lowest of the individual physician's actual charge for a procedure, that physician's usual charge, or the typical charge among physicians performing that procedure in the area. This latter limitation is referred to as the "customary charge", although Medicare uses the term "prevailing charge" to describe the same limitation. Many Blue Cross and Blue Shield Plans eliminate the usual charge limit and base payments on the lower of the actual charge or the customary charge.

In our private business, UCR-type payment arrangements are typically associated with medical and surgical "service" benefits programs. To deliver these benefits, all but a small number of Blue Cross and Blue Shield Plans rely on "participating" physicians who agree to accept Plan fee allowances as payment in full. Participating physicians are permitted to bill Plan subscribers only for co-insurance or copayments where those apply.

The physician participation concept is an important part of our private business. It eliminates paperwork for our subscribers and, most importantly, injects an element of financial predictability into subscribers' relationships with physicians. A Blue Cross and Blue Shield Plan's ability to achieve adequate participation among physicians depends on the existence of a reasonable level of payment and, importantly, on a strong committment to prompt claims service and responsiveness to provider problems. Generally between 75 and 95 percent of area physicians choose to become Blue Cross and Blue Shield Plan participating physicians where these arrangements are available.

Most UCR systems used by Blue Cross and Blue Shield Plans set an initial customary charge limit at the 75th-90th percentile of physicians' usual charges and then adjust this amount downward if it exceeds an established rate-of-increase limit. Some Plans

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limit increases in customary charge screens to specific economic indices, such as the CPI or GNP price deflator, while others base their limit on actuarial recommendations or Board of Directors' decisions. A majority of Plans, including those relying principally on fee schedules, update payment limits annually. In addition, most Blue Cross and Blue Shield Plan UCR systems recognize physician specialty in the calculation of customary charges.

The physician payment systems used by Blue Cross and Blue Shield Plans are very dynamic. New payment methods are being implemented and existing payment arrangements are being changed. Many of these changes involve less frequent updating of payment limits and incorporating incentives to encourage ambulatory surgery.

Though the price paid or payment method used is important it is less important in containing costs than programs that deal with variations in medical practice. New cost containment programs — for example, preadmission review, mandatory ambulatory surgery, patient care management, — have been established to address inappropriate use of services and sites of care. Plans have also moved aggressively to develop HMOs and Preferred Provider Products. Under these arrangements, Plans can effectively contain costs for physicians' services through innovative and flexible payment and utilization management programs that take advantage of the dynamic market forces that now exist in most areas of the country.

Blue Cross and Blue Shield Plans are addressing many of the same issues that Medicare must face in deciding how to refine physician payment in a way that balances sound program objectives and cost considerations. Consequently, the developments in the private market that I have described are an important consideration as the Committee examines Medicare physician payment.

MEDICARE'S CURRENT PHYSICIAN PAYMENT METHODOLOGY

Medicare calculates payments to physicians using the customary, prevailing and reasonable charge (CPR) method. Although the terminology is slightly different, the CPR approach is generally similar to the usual-customary-reasonable payment arrangements used by many private payers.

Since the program began, steps have been taken to control increases in the fees paid by Medicare to physicians. Early on, the prevailing charge limit on Medicare payments to physicians was dropped from the 90th to the 75th percentile of customary charges. In addition, the Medicare Economic Index, enacted in 1972, has been employed to keep physician payment increases in line with general inflation and physician practice costs. Congress, in the Deficit Reduction Act of 1984, mandated a 15-month freeze of Medicare's charge screens and physicians' actual charges to Medicare patients, effective July 1, 1984. This step increased further the disparity between actual charge levels and Medicare payment levels.

Another important aspect of Medicare's physician payment program is the policy concerning the assignment of claims. The physician's assignment decision determines whether or not beneficiaries will experience directly the consequences of Medicare's efforts to contain physician payment levels. Currently, physicians can choose each fall to become participating physicians and thereby agree to accept assignment on all of their Medicare claims for one year, or they can choose to accept assignment on a claim-by-claim basis.

PROBLEMS WITH THE CURRENT SYSTEM

From our perspective, the Medicare payment methodology, as it is currently structured, has a number of problems:

- o It is confusing to beneficiaries and physicians.
- o It is cumbersome to administer.
- o It is not sensitive to changes in the real costs of individual procedures.
- o It provides an incentive, as do all fee-for-service systems, to perform more rather than fewer services--the more services provided, the higher the physician's income.
- o It reflects existing charge patterns in the market for physician services, which many believe represent payment imbalances. Critics have argued that the existing system favors, beyond what is justified by actual resources, specialists over generalists, urban areas over rural areas, inpatient treatment over ambulatory care, technologically intensive procedures over primary care, and new procedures over established procedures.

Many of these problems exist to varying degrees in other fee-for-service payment methods as well. We would note, however, that despite its drawbacks, the Medicare physician payment system has thus far served the program well. It has helped to improve the financial access of the elderly and the disabled to high quality physician services. In addition, the system has been flexible; it has screened and set payment limits on the fee-for-service charges of large numbers of physicians in different communities, with different overhead costs and with different types of training, skills, and experience.

MEDICARE PHYSICIAN PAYMENT REFORM

In our view, Medicare physician payment reform should not be looked at solely as a reimbursement policy issue. Our experience in designing and administering physician

payment arrangements in the private sector has taught us that mechanisms to deal with the volume and mix of services rendered are more important than the techniques used to establish rates of payment. In addition, a critical measure of the adequacy of a payer's arrangements with physicians is the degree of predictability and financial protection they provide to patients. Therefore, no discussion of physician payment policy under Medicare can be complete without a discussion of Medicare's policy regarding the assignment of beneficiary claims. Finally, as emphasized by the recent debate over whether patients are being discharged from PPS hospitals prematurely, there is a critical need to monitor quality of care very closely under any revised payment system that would put providers at financial risk, thus providing incentives for underutilization.

Given that background, we would like to suggest six objectives for Medicare physician payment reform.

1. **Simplicity.** Any revised payment system should be easy for beneficiaries and providers to understand. Blue Cross and Blue Shield Plans that serve as Part B carriers tell us that a significant portion of all the beneficiary and provider inquiries they receive relate to misunderstandings about Medicare's reasonable charge methodology and disagreements with the results. A revised payment system should also be relatively simple to administer, although we recognize that some complexity may be necessary to assure equity.

2. **Reasonable financial protection for beneficiaries nationwide.** In designing a revised payment system, the Congress will have to weigh the advantages and disadvantages of setting national, regional, statewide, or smaller geographic area payment rates.

In this effort, we would urge that you give primary emphasis to the need to achieve some uniformity of financial protection for beneficiaries nationwide, rather than uniformity of rates. While large geographic variations in Medicare payment levels for physicians' services are a concern, we believe that large variations in the Medicare assignment rate are a greater concern. In our view, establishing rates of payment on a national basis should not, in itself, be an objective of Medicare physician payment reform. National payment rates could result in greater disparities than exist now in the financial protection that Part B provides to beneficiaries.

3. **Efficiency.** The revised payment system should promote the cost effective delivery of high quality care to Medicare beneficiaries. It should provide for payments that are reasonable, considering the dynamics of the marketplace for physicians' services and the need to assure that beneficiaries have reasonable access to quality care.

4. **Predictability.** Beneficiaries are served best by a payment system that enables them to predict with reasonable certainty the potential financial liability they will face when they seek care. Also, physicians and other practitioners can manage their practices more effectively and engage in meaningful planning if they know in advance how much Medicare will pay for their services.

5. **Maximum use of market forces, where feasible and appropriate, to contain costs.** The growing supply of physicians provides payers with opportunities to negotiate contractual arrangements having more stringent payment and utilization management provisions than ever before, while still maintaining high levels of participation. It

is important to note, however, that physician supply does vary dramatically from area to area and among physician specialities. This variation in market conditions reinforces the importance of program flexibility, which is another key objective of Medicare physician payment reform.

6. **Flexibility.** The problems faced by beneficiaries, providers, and the Medicare program regarding the financing and delivery of physicians' services vary in different areas of the country. In some areas, Medicare prevailing charges may be overpriced for certain procedures performed by an excess supply of certain specialists, while in other areas beneficiaries may have very limited access to needed specialists. Similarly, the availability of participating physicians varies greatly in different parts of the country.

In our private business we have been successful in our cost containment efforts by tailoring solutions to the problems that exist at the local level. Under any revised payment system for Medicare, HCFA should be provided the authority to depart from whatever payment methodology is adopted, either through waiver provisions, exceptions provisions, or experiments proposed by carriers. We believe that providing this flexibility will be critical to the system's success.

OPTIONS

With these objectives in mind, I would now like to address the options and our recommendations concerning the three critical elements of Medicare physician payment reform: the method of paying physicians, utilization review, and the assignment policy. In addition, I will discuss capitation approaches because they permit these elements to be addressed effectively by managed care programs developed by private sector organizations.

Payment Methods

The major alternatives to the current CPR system that have been identified are per case fee schedules and per procedure fee schedules.

Physician payment on a per case basis, possibly using DRGs in some way, is conceptually appealing because theoretically it reduces any incentives for increases in the volume and type of procedures and tests. It, therefore, has considerable potential to promote efficiency. At present, however, per-case fee schedules are infeasible. First, most physicians are not organized to manage the substantial financial risks per case payments would pose. Unlike hospitals, most physicians do not treat sufficiently large numbers of similar cases to be able to balance high and low cost cases with reasonable predictability. As a consequence, many physicians might have strong financial incentives to see fewer Medicare patients, to refer the more complex and time consuming cases to other physicians, or, in extreme cases, to cut corners in delivering or ordering needed care. In addition, attending physicians would have an incentive not to involve consulting physicians in patient care management, and this could have adverse effects on quality of care.

There are other problems as well, such as whether to make per case payments to individual attending physicians or to entities such as hospitals, hospital medical staffs or physician groups. In any event, the difficulties inherent in distributing per case payments among anesthesiologists, assistant surgeons, and other physicians could, in light of current assignment policies, result in substantial financial liabilities for Medicare beneficiaries. For these reasons, we do not believe that per case payment is currently a realistic option for reforming Medicare's physician payment program.

Further research of the methodologies and analysis of the policy issues underlying a per case payment mechanism are, however, appropriate. We recommend that the federal government continue such efforts, with particular emphasis on determining how physicians can be organized to manage the risks inherent in a per case payment system.

We believe that until we have better information and understanding of the issues relating to per case payment, Medicare should consider per procedure fee schedules as a more realistic reform objective. Achieving two key objectives — simplicity and predictability — will be very difficult unless Medicare moves to fee schedules. Fee schedules could be developed based on existing charge patterns or a relative value scale. In addition, flexibility could be provided for adjustments and possibly alternative approaches at the local level. The fee schedules could be phased in over a multi-year period. Weights for the relative value scale could be developed from charge data initially and when feasible using resource cost measurement methods, taking physician concerns into consideration. Collapsing of procedure codes for related procedures would reduce incentives for physicians to fragment their billing for procedures and manipulate codes to increase their revenues. Implicit in this is that very little purpose can be served by moving from a distorted CPR system to a distorted fee schedule based upon it. Fee schedules are a potentially useful reform, but the reform should follow the development of measuring devices to rationalize payment. In the interim, the unsupportable extremes of CPR, both high and low, can and should be addressed within the CPR system.

A major advantage of fee schedules is that they are relatively predictable and easy to understand in that the amounts payable by Medicare can be readily learned in advance by beneficiaries and physicians. However, even carefully designed per procedure fee

schedules can have many problems. Fee schedules do not, by themselves, control service utilization. Another major concern is the levels at which fee schedule allowances are set and the effect these levels can have on physician participation and assignment rates. It may be very difficult to design fee schedules that produce substantial participation and assignment rates and also maintain budget neutrality.

As work is underway to address the design features of a per procedure fee schedule, some modifications could be made to CPR to make it more acceptable and to facilitate a smooth transition to a fee schedule. For example, increases in prevailing charges in a particular locality could be disallowed where they would bring the area to more than 25% (or some other percentage) above a state's average. Also, if a Medicare relative value scale is developed before the implementation of a fee schedule is feasible, wide disparities in the charge screens between specialists and non-specialists could be reduced in the CPR system by use of such a scale. Collapsing codes for nearly identical procedures and implementing more global charge categories could reduce incentives for physicians to fragment billing for procedures performed during the course of treatment. The pending Medicare budget reconciliation legislation does contain proposals to direct an independent body to examine these and other issues related to the CPR system and to make specific recommendations to the Congress. We believe that this approach would be an important step in the right direction.

Utilization Review

As indicated previously, the number of types of services furnished to Medicare patients is the most important variable influencing total costs. Volume increases unrelated to population growth and changing technology were responsible for 40% of the total growth in Medicare Part B expenditures from 1980 to the present.

Revisions to Medicare's current payment system or the establishment of a per procedure fee schedule would not by themselves explicitly address the utilization of physicians' services. We believe that the best approach to controlling utilization under fee-for-service payment systems is through aggressive medical and utilization review (MR/UR) by payers.

In recent years, MR/UR has received greater attention. A 1983 GAO report identified substantial savings that result from Part B carrier pre-payment review activities. Also, this committee in 1982 in TEFRA, and in this year's budget reconciliation bill, authorized additional funds for Medicare contractor MR/UR activities in recognition of the program savings these activities achieve. In the private sector, our MR/UR activities, coupled with innovative benefit design features that provide incentives for appropriate utilization, have contributed to significant reductions in the growth of health care costs.

If medical and utilization review of Medicare services is to be an integral part of any physician payment reform effort—and we think it should be—a number of critical issues should be addressed. First, the funding for carrier MR/UR activities and claims processing activities, which by themselves detect and prevent Medicare payment for millions of dollars of medically unnecessary care, needs to be more predictable, stable, and adequate to do the job properly. Second, experiments should be conducted to test the feasibility and desirability of evaluating carrier performance on the basis of ability to control Medicare expenditures and providing explicit incentives to carriers for effective MR/UR. Third, carriers should be provided greater flexibility to develop and implement cost-effective MR/UR screens based on their private sector experience.

Fourth, and most importantly, changes in the PRO law and its implementation should be made to assure that Medicare MR/UR is performed in the most effective and efficient

manner. We urge you not to overlook the considerable MR/UR resource that Medicare now has in its carriers and intermediaries. Medicare contractors overall have performed well in this area given current program objectives and constraints, and the system has the capacity to do much more if efforts are made to address the critical issues outlined above. We recommend that the Congress not assume it is necessary to expand PRO MR/UR activities to all covered services in all areas if an intermediary or carrier that conducts MR/UR as an inherent part of program administration can do the job more efficiently and effectively. In such areas, we believe that PRO activity would be more appropriately directed to the review of the quality of Part B services.

We also recommend that Congress change the PRO law to remove the arbitrary disadvantage that intermediaries, carriers, and other payer organizations now face when bidding for PRO contracts. Under current law and policy, while payer organizations may bid to become PROs, they cannot be selected if there is a qualified physician organization available. Even if the payer organization scores higher on the selection criteria, it cannot be selected as the PRO over a less qualified physician organization. Blue Cross and Blue Shield Plans make extensive use of physicians in both Medicare and private MR/UR activities. In our view, Medicare should be permitted the option of selecting whatever organization can best meet the process and outcome measures it sets for the PRO program.

Medicare Assignment Policy

We have recently seen a dramatic increase in the assignment rate. While these results are encouraging, we believe that the best policy for Medicare assignment is an "all or none" system under which a physician must choose periodically whether to accept assignment for all Medicare claims or for no Medicare claims. Under an "all or none"

system beneficiaries would continue to be reimbursed directly by Medicare for services provided by non-participating physicians. Importantly, this policy would be much easier for beneficiaries to understand. Also, over time, this policy offers the greatest potential to increase the Medicare assignment rate without government coercion because it takes full advantage of the changes that are occurring in the market for physicians' services. As the supply of physicians and beneficiary understanding of this simpler system increased, the advantages of becoming a Medicare participating physician would likewise increase. The "all or none" approach would position Medicare better to experiment with innovative cost containment approaches now being used by the private sector, such as preferred provider arrangements. While any change from the current system is likely to result in some physicians deciding not to participate any longer, we believe that on balance beneficiaries and the Medicare program would be better off under an "all or none" assignment policy.

Capitation

Although a modified CPR system, fee schedules, enhanced MR/UR, and "all or none" assignment are desirable, it is our view that HMO, CMP, and carrier capitation arrangements offer the greatest potential for efficiency and predictability, while preserving reasonable beneficiary access to high quality care. Capitation arrangements that transfer the underwriting risk of Medicare to private organizations will enable the government to take advantage of and reinforce the competition now under way in the private sector. The private sector has taken great strides in fashioning new, locally-oriented cost containment programs.

Although it is possible to capitate an organization for only Part B benefits, we believe that integrated benefits management argues strongly for combined Part A and Part B

capitation. As indicated previously, physicians' decisions have important implications for the use of hospital and other health services. Capitation, through HMOs and CMPs, is an approach already being used by Blue Cross and Blue Shield Plans and Medicare. However, many beneficiaries have no access to HMOs and CMPs or do not wish to change physicians.

A number of Blue Cross and Blue Shield Plans are exploring with HCFA a different approach called "carrier capitation". Under this approach, a Medicare contractor would receive a capitated amount per beneficiary and all Medicare beneficiaries in a geographic area would be included except those enrolled in other HMOs and CMPs. The contractor could offer a variety of health benefit plans, including the traditional Medicare plan, a fee-for-service plan with enhanced benefits management features, such as pre-admission review, and an HMO option. Beneficiaries could opt to enroll in alternate plans or continue to receive the existing Medicare benefit package from their traditional providers. We strongly endorse geographic capitation and believe that the approach can be implemented in the near-term in some areas of the country. Critical to the success of this approach is the establishment of fair and predictable capitation payment rates that enable the contractor to effectively manage the considerable risk that would be involved.

CONCLUSION

Mr. Chairman, you and the Members of your Subcommittee face a difficult set of choices with respect to physician payment under Medicare. The major options are clear, but there are severe practical limits on the extent to which new approaches can be pursued in the short term. I have outlined the major directions which we believe offer the best hope for the future and have suggested some realistic steps which can be taken in the near term.

I would be pleased to respond to questions.

TESTIMONY

OF

FRANKLIN B. McKECHNIE, M.D.

PRESIDENT

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

REGARDING

MEDICARE PART B PAYMENT FOR PHYSICIAN SERVICES

BEFORE THE

SENATE COMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH

SENATOR DAVID DURENBERGER, CHAIRMAN

DECEMBER 6, 1985

Mr. Chairman and Members of the Committee. My name is Franklin B. McKechnie. I am a practicing anesthesiologist in Winter Park, Florida, and the current President of the American Society of Anesthesiologists, a national medical society with a membership of approximately 21,000 physicians engaged in the practice of or interested in anesthesiology.

For a number of years our members have used the Relative Value System as a basis for reimbursement and indeed are currently required to do so under Part B of Medicare. The Society has published Relative Value Guides for a number of years, is familiar with the methodology and the practical considerations associated with their use, and is, to my knowledge, the only medical specialty currently employing a Relative Value System for Medicare.

I therefore appear before you to advocate your consideration of the Relative Value System as a means of physician reimbursement. My remarks may perhaps be better understood if I provide you with a brief description of what an anesthesiologist does. Our most important function, as I am sure you all know, is to administer a number of drugs to render patients insensible to pain during surgical and obstetrical procedures. In most cases, these drugs suppress the patient's ability to maintain his own life. It is the anesthesiologist who is responsible for keeping the patient alive by assuring that essential physiologic systems function properly during the course of

the anesthetic. This is done by (1) monitoring such vital signs as blood pressure, pulse rate, color, temperature and heart sounds and (2) diagnosing and treating any deviations that may arise during the course of the surgical procedure. Our principal concern then deals with the status of the respiratory, cardiovascular, hepatic, renal and central nervous systems. These activities are performed during, but independent of, the surgical procedure.

The drugs that are administered to achieve the anesthetic state are in themselves potentially lethal when used in inappropriate doses or improperly selected for a particular patient. Each patient must be evaluated prior to the administration of the anesthetic which should be done by, or under the direction of, a qualified anesthesiologist. Responsibility for the patient's physiologic balance extends into the post-anesthesia period. Simply stated, the anesthesiologist seeks to maintain the patient's physiologic function in as near a normal state as possible while rendering the patient insensible to pain during an operation. The anesthesiologist also has a responsibility for the patient's care during his or her recovery from anesthetic agents. It might be said that the anesthesiologist is the patient's surrogate in the operating room, acting for the unconscious patient who cannot act for himself or herself.

In any discussion of the Relative Value Guide, it is important for the Committee to understand how the complexity of the anesthetic procedure relates to the complexity of the surgery, as well as the severity of the patient's illness. Since our concern is primarily with the respiratory and cardiovascular systems, it stands to reason that surgery on these systems adds complexity to the anesthetic. Such complexity can be further compounded by the patient's

physical condition, his age, whether he smokes or not, his positioning on the operating table, etc. These considerations form the basis for the Relative Value Guide, which we believe continues to be the most accurate means of providing proper compensation for anesthesia services.

The current guide published by the ASA contains a listing of approximately 400 surgical procedures. It is appropriate to note that no individual anesthesiologist or insurer is under any compulsion to use the ASA guide and in fact, many different RVGs are in use for anesthesia services by Medicare carriers. Here are three examples from the ASA RVG:

Anesthesia for procedures on the upper abdomen (e.g., removal of a gall bladder)

Anesthesia for amputation of the lower leg

Anesthesia for removal of a lung or portion thereof

To create an RVG, one assigns to each procedure a number which, when compared to the number assigned <u>another</u> procedure, described the <u>relative</u> complexity of the two procedures. In the examples I just cited, anesthesia for removal of a gall bladder has been assigned, in the current ASA Guide, a value of "7", for an amputation of the lower leg a "3", while surgery on the lung is valued at "15". In comparing these numbers one can see that anesthesia for lung surgery is regarded as almost twice as difficult as anesthesia for removal of a gall bladder and four times as difficult as anesthesia for a lower leg amputation. This illustrates the point that the most complex procedures involve the respiratory and circulatory systems.

Another extremely important aspect of the Relative Value Guide as used by anesthesiologists is the factor of <u>time</u>. Merely describing the relative

complexity of various procedures does not take into account the wide range of time that surgeons may require to accomplish their tasks. As a consequence, all anesthesia Relative Value Guides also include unit values for time - usually one unit for each 15 minutes. Again, using one of the examples previously mentioned, the unit values assigned for anesthesia for removal of a gall bladder requiring 2.0 hours would be 15 (7 for the procedure and 8 for the time units).

The American Society of Anesthesiologists believes this to be the fairest and most appropriate method of assessing the services performed by an anesthesiologist, in that it considers both the complexity of the anesthesia service and the time required to perform these services under different medical and institutional settings. With regard to service, ASA's Relative Value Guide measures the complexity of the service rendered in the operating room as well as the pre-operative evaluation and the post-operative care for the patient. Regarding the time factor, the guide takes into account the wide variation of time required to perform that service which occurs not only within individual hospitals but between surgeons in the same institution and, indeed, on a case by case basis for each surgeon. Applying a simple average time to each procedure would ignore these considerations and seriously distort the intensity of care and commitment to any one patient (as illustrated by our first attachment).

Once an RVG has been constructed, the creation of an RVG-based fee schedule is simple. One need only determine what will be charged per unit. This "conversion factor" is then multiplied by the RVG generated number.

Anesthesiologists favor the RVG method because we feel it is fair for the patient, the physician and third party carriers. In addition, it provides a quick and objective measure of the appropriateness of a particular fee, as well as allowing one to make comparisons between anesthesiologists and their fees for any particular procedure. Attached is a supplemental statement on the Relative Value Guide, expressing our views in greater detail.

We also feel that the RVG can be made to work for a host of medical services under the Medicare Program. This, of course, assumes that the relative values which are established reasonably reflect the differences and complexity of the service rendered, taking into account the time and skill involved. We believe establishing a Relative Value System can best be accomplished with major input from organized medical societies; and any legislation implementing the RVG concept or other payment for services approach for Medicare Part B should include appropriate provision for participation by the physician community.

Now, if I may, I would like to turn to the subject of patient safety. In our judgment, the issue of reimbursement for services, while important to our membership, is of less concern than the strict control of anesthesia mishaps and near-misses. Although anesthesia in this country is probably the safest in the world, the objective of our Society is to eliminate, insofar as possible, every case of anesthesia-related mortality or morbidity. We know from a number of studies that many of the mishaps in anesthesia that do occur are due to human error and, therefore, preventable.

To this end, the Society has been working closely with the Food and Drug Administration on a variety of important projects. At our recent annual meeting, the Society funded the establishment of an Anesthesia Patient Safety

Foundation. This will enable a cooperative research effort among anesthesiologists, manufacturers of equipment, hospitals, the insurance industry, risk managers, the government and others, aimed at improving patient safety. We have also charged a committee with proposing standards for anesthesia care, again, in an effort at improving patient safety. These programs are more fully described in the supplemental materials attached to this statement.

An excellent summary of contemporary anesthetic practice appeared in a recent issue of Newsweek (attached). I trust you will forgive this digression from the subject of reimbursement. How we are fairly paid for our services to Medicare patients is important, but what we do for our patients and how well we do it, must be of utmost concern.

On behalf of the ASA, I wish to express my appreciation for the opportunity to appear today. I will be happy to respond to your questions.

December 1985

THE RELATIVE VALUE GUIDE; ITS USE AND DEVELOPMENT UNDER MEDICARE PART B

What the Relative Value Guide Is

The Relative Value Guide ("RVG") developed by the American Society of Anesthesiologists ("ASA") is a means of describing and measuring professional services provided by an anesthesiologist. It consists of a list of medical procedures that are individually described in medical terminology and by reference to abstract numbers, known as "unit values". These unit values characterize the relative degree of difficulty, risk and skill and the time involved in performing the professional anesthesia services relating to such procedures. By multiplying a monetary value -- a "conversion factor" -- by the RVG unit values relating to each anesthesia procedure, individual anesthesiologists and third-party payors may construct a schedule of fees that will be charged or charges that will be paid, as the case may be, for anesthesiology services.

Why the RVG is Necessary

A unique aspect of the practice of anesthesiology is that there is no necessary correlation between a given surgical procedure and the anesthetic procedure performed in connection with such surgery. There are variations in difficulty, risk, time and other factors vital to the anesthesia problem that are unrelated to the surgical procedure. For that reason, the charges of an anesthesiologist typically vary substantially as between different persons undergoing the same surgical procedure and as between operations by slow and fast surgeons.

With the rapid growth of third-party mechanisms in the 1950's, third-party payors needed a commonly accepted method of describing the content and

defining the extent of professional anesthesia services, in order to evaluate anesthesia charges and to compute actuarially the premium necessary for their policies. In order to avoid having payment based upon an arbitrary formula related to a percentage of surgical fees or a fixed dollar amount per unit of time, the first ASA RVG was developed in 1962 in order to define the variables that enter into anesthesia fee determinations.

Factors Measured by the RVG

The RVG system has the benefit of basing compensation for anesthesiologists' services upon the actual content of those services. The factors that are reflected in charges for anesthesia services include the following:

1. the time involved in performing anesthetic procedures;
2. anesthesia risk, including the patient's physical status, the degree of hazard imposed by the depth of anesthesia required, the type of anesthesia and technique, and the potential complications incident to anesthesia;
3. the magnitude of the surgical procedure and the degree of anesthesia hazard imposed by the site of the operative field and the position of the patient;
4. the technical skill required of the anesthesiologist, including problems relating to maintenance of normal respiratory and circulatory physiology and problems incident to specialized techniques and procedures; and
5. pre-operative evaluation and post-operative care.

The time factor is extremely important in determining charges for anesthesia services, since the anesthesiologist has no control over how long a given surgical procedure will take. ASA recently informally surveyed members of its Committee on Economics concerning the minimum and maximum time involved

in the ten procedures most commonly performed on Medicare patients. The survey revealed radical variations in the time necessary for a given surgical procedure. The differences in time are important not only to reimbursement, but to the degree of hazard involved and the technical skill required as well.

Effectiveness of the RVG

The ASA RVG facilitates communications between anesthesiologists and third-party payors and makes the profiling of anesthesiology fees practicable. Specifically, it enables anesthesiologists adequately to describe the services that were rendered when they submit statements for services to insurers, and it provides third-party payors with a method of analyzing anesthesiologists' actual charges so as to factor out variables associated with the services rendered. Insurers thus can compare the fees of one anesthesiologist with those of another, and even compare the fees of a single anesthesiologist for similar services in different procedures.

Subsequent revisions of the ASA RVG have kept the RVG current with developments in medical practice. It or other relative value guides are widely used both by third-party payors and by anesthesiologists throughout the country.

The RVG and Medicare

Current HCFA regulations call for reimbursement of anesthesiologists on an RVG methodology. Medicare carriers employ a variety of RVG's, some developed by ASA, some by the carrier itself, and some based on relative value studies developed in California several years ago. It is believed that anesthesiology services are the only medical services currently paid for on an RVG basis, primarily because ASA was successful, in antitrust

litigation brought by the Justice Department, in defending its right to develop an RVG as a guide for physicians and third-party payors.

Significant interest now exists in the Congress and HCFA in developing an RVG-based fee schedule for all physician services under Medicare. ASA supports these initiatives, as long as any RVG so developed takes appropriate account of the time factor involved in anesthesia procedures and of the major variations in time which occur in actual practice. ASA believes that to be workable and fair as the basis for reimbursement, any RVG must in the last analysis be the product of a joint effort between the physician community and third-party payors, and believes that any legislation authorizing development of an RVG for Medicare Part B should include appropriate provision for participation by the physician community.

December 1985

PEER REVIEW, PATIENT SAFETY AND RISK MANAGEMENT: CURRENT INITIATIVES

One of the most important current areas of ASA activity involves a comprehensive program to achieve improvement in the quality and safety of anesthesia care in the United States. Major segments of the program include the following:

On-site peer review. Since 1982, ASA has through its Committee on Peer Review made available to the nation's hospitals and their medical staffs the opportunity to receive an on-site evaluation of anesthesia services rendered in the hospital. On-site visits, normally two days in duration, are made by a disinterested team of anesthesiologist evaluators, and a comprehensive, candid written report of the evaluation is provided to the hospital and medical staff. Approximately 35 requests for this service have been received since inception of the program, and some 18 evaluations have been completed to date, with an additional six to be completed.

Patient Safety videtotapes. In the past 18 months, ASA through its Committee on Patient Safety and Risk Management has been engaged in production of a six-part videotape series on patient safety. The series is designed for use by anesthesia staffs and individuals in training. Topics include proper checkout of anesthesia machines, anesthesia record-keeping, and common causes of anesthesia mishaps. Three of the six films are being produced with the cooperation of the Food and Drug Administration.

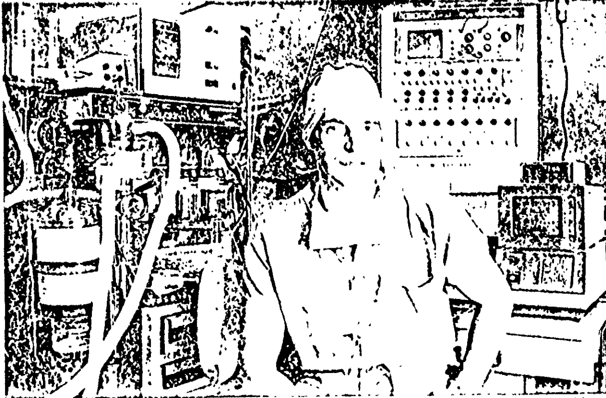
Development of generic machine checkout. In collaboration with the FDA and manufacturers of anesthesia machines, ASA has developed a generic machine check-out form for use by anesthesia personnel prior to undertaking an anesthesia procedure. The purpose of the effort is to reduce anesthesia mishaps that may be traceable to equipment failures, by providing operators with a checklist of steps to be followed, prior to starting a procedure, to insure the equipment is operating properly.

Improvement of DEWS. In a related effort, ASA and the FDA are working to establish a system -- known as Device Early Warning System -- for the reporting of incidents, including "near misses", which occur in the course of administration of anesthesia. The essential concept is to provide a system to identify potential problems with anesthesia equipment and to provide equipment users with advance information on how to avoid such problems.

Establishment of Patient Safety Foundation. In connection with its annual meeting in October, 1985, ASA approved the establishment of the Anesthesia Patient Safety Foundation. The purposes of the Foundation include fostering investigations that will provide a better understanding of preventable anesthetic injuries and encouraging programs that will reduce the number of those injuries. The Foundation will be governed by a 30-person Board, including representatives of the following: anesthesiologists, anesthesia equipment manufacturers, insurers, hospitals, non-physician providers, attorneys and the FDA. ASA has underwritten the activities of the Foundation to the extent of $100,000 per year.

Standards of Practice. ASA's House of Delegates in October, 1985, approved appointment of a committee charged with responsibility for proposing ASA-approved standards of anesthesiology practice. In creating and publicizing such standards, the objective will be to raise the quality and safety of anesthesia care throughout the United States.

MEDICINE



Cottrell surrounded by banks of monitoring equipment: Each patient presents a fresh set of problems

Doctors You Can't See

New drugs give anesthesiologists a critical role.

When the surgical team that performed cancer surgery on President Reagan last summer stepped before the cameras to herald their success, no one seemed to notice the absence of one key member: Dr. H. F. Nicodemus, the chief of anesthesiology at Bethesda Naval Hospital. It was no surprise to anesthesiologists themselves. Knife-wielding surgeons have always held the operating room spotlight. "An anesthesiologist is a mysterious person," says Dr. John J. Sassano, director of cardiovascular anesthesia at Pittsburgh's Presbyterian-University Hospital. "There are no TV shows about us, and some people are even surprised to learn we are physicians."

Yet even the most skilled surgeons give anesthesiologists credit for much of what they are able to do in the operating room. It is not just a matter of keeping a patient unconscious and out of pain during an operation. The anesthesiologist also breathes for the patient with a mechanical respirator and monitors the patient's blood pressure, heart rate and temperature. And he is in charge of administering blood and drugs as needed. "The anesthesiologist is the patient's surrogate in the operating room, acting for the unconscious patient who can't act for himself," says Dr. Howard L. Zauder, chief of anesthesiology at the State University of New York Upstate Medical Center, Syracuse. Dr. John P. Bunker, former chief of anesthesiology at Stanford University School of Medicine, puts it more bluntly: "While a surgeon's mistake may leave you impaired, an anesthesiologist's mistake can lead to death."

Anesthesiologists have other less well-known but important duties outside the operating theater. They are responsible for taking care of respiratory emergencies wherever they occur in the hospital: emergency wards, delivery rooms and pediatric wards. They are on the staffs of coronary and other intensive-care units. And they pursue their specialty in the treatment of chronic pain; many pain clinics now are run by anesthesiologists.

Nightshade: The field wasn't always so attractive. For centuries the methods of fighting surgical pain were crude in the extreme. If patients got anything more than a piece of wood to bite hard on, it was likely to be a drug like nightshade or hashish mixed with wine. Doctors also knocked patients out by pressing on the carotid arteries of the neck, temporarily cutting off the blood supply to the brain. Neither drugs nor semistrangulation worked very well, so most surgeons had to perform their operations with the patient still conscious—placing a premium on speed. One hundred and fifty years ago, it is said, a good New England surgeon could amputate a leg in 26 seconds.

Anesthesiology became a bit more scientific with the introduction of nitrous oxide (laughing gas), chloroform and ether. In 1842 a Georgia physician, Crawford W. Long, removed two small tumors from the neck of a patient after giving him a few whiffs of ether. A Boston dentist, Dr. William T. G. Morton, began giving his patients ether during dental extractions. He then persuaded a leading surgeon of the day, Dr. John Collins Warren, to try it in a tumor removal at Boston's Massachusetts General Hospital in 1846. The operation was widely publicized and convinced other surgeons that anesthesia (a word coined by Dr. Oliver Wendell Holmes from the Greek "without perception") was here to stay.

Still, until well into this century, putting patients under anesthesia was regarded as an undemanding task, often turned over to nurses. (Today there are 23,000 specially trained nurse anesthetists in the United States who are partners on the anesthesiology team.) As a specialty for physicians, anesthesiology came into its own only after World War II. Experience gained in the treatment of serious battlefield wounds led to a daring new era of surgery in peacetime, including open-heart operations and transplants. And none of this would have been possible without the parallel development of new anesthetics and new ways to use them. Among the innovations were fast-acting, fluoride-related anesthetic gases. These are less likely than others to induce nausea, and are also nonflammable—eliminating the risk of explosions in the operating room.

Other important new drugs include short-acting, potent narcotics that don't depress heart and circulatory function as much as such standbys as morphine and Demerol, short-acting muscle re

Anesthesiologist at work: Patient's surrogate

BEST AVAILABLE COPY

[illegible] drugs [illegible] which [illegible] making the other preoperative medications easier to administer. Thanks to drug developments, anesthesia can be tailored to the patient's special needs and vulnerabilities, notes Dr. Joseph F. Artusio Jr. of New York Hospital-Cornell Medical Center. "If a patient is asthmatic, we can administer an anesthetic that dilates the bronchi," he says. "If a patient has kidney disease, we use a muscle relaxant like atracurium, which isn't excreted by the kidney."

A Talented Hand: But the drugs are a double-edged [illegible]. "They are more accurate, more precise, more powerful," says Sassano, "but they are also more dangerous. They require a more talented hand." For that reason the anesthesiologist's responsibility to monitor the patient has grown even more critical. An array of complex electronic devices has been developed to help. A recent operation at the SUNY Downstate Medical Center in Brooklyn illustrates the intricacies of the anesthesiologist's job.

The patient was a 45-year-old woman who had suffered a succession of strokes that deprived her temporarily of speech and all movement on her right side and also impaired her memory. The neurosurgeons' task was to reroute an artery in her temple to another blood vessel, bypassing the blocked artery that had caused the strokes and restoring blood flow to her brain. In the operating room, a team of three anesthesiologists, headed by Dr. James E. Cottrell, went to work. By intravenous infusion they administered the barbiturate Pentothal, the synthetic narcotic fentanyl and a muscle relaxant. Then they gave her nitrous oxide, intending to keep her on what anesthesiologists call a "light plane": not so deeply anesthetized as to make it difficult to detect lack of oxygen in her brain, but not so light as to let her drift into awareness. The muscle relaxant kept the patient paralyzed, since the slightest movement during the delicate surgery could be fatal.

During the next six hours the anesthesiologists stood guard over an array of tubes, flashing lights and blinking digital displays. They drew blood samples periodically from an arterial line in her wrist. By means of a catheter threaded through her neck into the right atrium of her heart they measured cardiac function. Her temperature was taken constantly by a probe lying in her esophagus. An electrocardiogram continuously recorded her heart rhythm and rate, and an [illegible] of her [illegible] ways.

Several times the patient's blood pressure shot up. Cottrell gave her more Pentothal and finally switched her from nitrous oxide to an anesthetic less likely to aggravate such rises. When monitors showed a fall in oxygen to her heart muscle, the anesthesiologists administered nitroglycerin. When the pressure in her right atrium rose, the doctors assumed she was retaining too much water and stopped giving her intravenous fluids. Finally, Cottrell breathed a sigh of relief. "The worst is over," he said. "I think we have a feel for her." At the end of the operation, the anesthesiologists gave a drug to reverse the action of the muscle relaxant, wheeled her to the recovery room and slowly weaned her off the ventilator.

Morton (left) and Warren: Anesthesia made respectable

Modern anesthesiology has improved survival for surgical patients and made hitherto unthinkable operations feasible. Among patients recently recovered from heart attacks, for example, the risk of dying during surgery has dropped from 25 percent to only 2 to 5 percent in just the last 5 years. Meticulous monitoring makes possible major surgery on the tiniest babies, in whom the slightest error in the infusion of fluids could prove fatal. Newer techniques of anesthesia give surgeons vital time to do their work. A limb reattachment can take 18 to 24 hours, for example. Keeping a patient asleep that long, says Zauder, "is no mean feat. You have to prepare for all manner of metabolic changes with those patients ... plus they can lose up to 200 units of blood."

With so many things that can go wrong, [illegible] the monitoring of vital signs, it's easy to see why an anesthesiologist's [illegible]. The most common injury related to anesthesia is damaged teeth from the insertion of the endotracheal tube used to deliver the anesthetic. The most serious, but fortunately rare, occurrence: "undiagnosed disconnect," in which the patient comes unhooked from the anesthesia equipment. An anesthesia-related death is estimated to occur in 1 in 10,000 to 20,000 operations. Most such deaths, anesthesiologists agree, are the result of human error. "There may be simple surgery, but there is no simple anesthesiology," says Dr. Marilyn M. Kritchman, director of the anesthesiology residency education program at New York University Medical Center. Fatigue accounts for some of the mistakes. Many of the most demanding operations for the anesthesiologist, such as multiple-injury auto accidents, occur in the middle of the night. In many cases disaster is simply unavoidable: a patient may react unpredictably to a drug or suffer unexpectedly a massive loss of blood.

Risks and Rewards: These risks make anesthesiologists highly vulnerable to malpractice suits. Annual malpractice insurance premiums range from $5,000 to $40,000. Yet anesthesiologists are better off than obstetricians and neurosurgeons, whose insurance may cost more than $100,000 a year. The pay, on the other hand, is good: average annual income for an anesthesiologist approaches $145,000—about the same as for a surgeon, and far better than the approximately $70,000 that family practitioners and pediatricians earn on average. Furthermore, most anesthesiologists work in groups within hospitals, which spares them the expense of office overhead.

Indeed, anesthesiology is now one of the most popular specialties. The number of anesthesiologists has risen from 8,000 to more than 21,500 in the last decade. Residency programs, which involve three years of clinical anesthesia training plus a year of general clinical work, are always full. "The quality of physicians now coming into the specialty is superb," says Bunker. In part, that's because doctors find anesthesiology, with all its tensions and demands, intellectually challenging, as well as financially rewarding. The anesthesiologist is part internist, part technician and part pharmacologist, and each patient presents a fresh set of problems for him to solve. "It is probably the most exciting specialty in medicine today," says Artusio. "It is attractive to young, eager minds."

MATT CLARK with MARIANA GOSNELL and DEBORAH WITHERSPOON in New York

December 1985

TIME VARIATIONS FOR ANESTHESIA PROCEDURES

In early 1985, ASA informally surveyed a very limited number of its members to determine whether, as was believed, there was substantial variation in the amount of time devoted to various anesthesia procedures. Respondents were asked to report minimum and maximum times, during a representative period, for the ten most common anesthesia procedures performed at their institution or by their anesthesia group.

The following is a brief sampling of the data received from four of the anesthesiologists surveyed, showing minimum and maximum time for six common procedures:

AMA CPT-4 CODE NUMBER	NAME OF PROCEDURE	DOCTOR A MIN/MAX*	DOCTOR B MIN/MAX*	DOCTOR C MIN/MAX*	DOCTOR D MIN/MAX*
00562	Anesthesia for procedures on heart, pericardium and great vessels of the chest, with pump oxygenator	3.30/ 12.30	1.25/ 11.40		3.30/ 9.00
00790	Anesthesia for intraperitoneal procedures in upper abdomen	1.05/ 6.30	1.10/ 11.40	0.45/ 8.15	1.15/ 5.45
00910	Anesthesia for transurethral procedures	0.40/ 4.40	0.20/ 3.05	0.15/ 2.15	0.30/ 2.30

* Times are stated in hours and minutes, e.g. 5.45 represents five hours and forty-five minutes. Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may safely be placed under post-operative supervision.

AMA CPT-4 CODE NUMBER	NAME OF PROCEDURE	DOCTOR A MIN/MAX*	DOCTOR B MIN/MAX*	DOCTOR C MIN/MAX*	DOCTOR D MIN/MAX*
00914	Anesthesia for transurethral resection of prostate	1.00/ 2.10	0.50/ 3.40	0.45/ 2.15	0.45/ 2.45
01214	Anesthesia for total hip replacement or revision	2.00/ 5.45	2.00/ 10.45		1.45/ 3.45
01270	Anesthesia for procedures involving arteries of the upper leg	2.15/ 5.45	1.55/ 9.20	0.45/ 9.15	0.45/ 5.00

The sampling discloses radical variations, up to a ratio of about 10:1, between the minimum and maximum times devoted to a particular procedure. Because of the smallness of the sample, it is not possible to state whether the sample is representative, and a broader survey is now underway. ASA has no reason to believe, however, that the larger survey will produce results significantly different from the sample.

The time factor is important in measuring anesthesiology services for two reasons: First, such a methodology gives recognition to the professional time actually devoted to a particular patient; second, and equally important, the time factor gives recognition to the fact that unlike most surgical procedures, an anesthesia procedure almost always carries proportionately higher risk, and therefore complexity for the anesthesiologist, the longer it is necessary to maintain the patient in an anesthetized state.

[Whereupon, at 12:36 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

FEB 27 1986

Mr. Edmund J. Mihalski
Deputy Chief of Staff
for Health Policy
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Ed:

Enclosed are our responses to the questions for the record from Senator Dole regarding the December 6th hearing on Medicare physician payment reform.

If you have any questions please contact Nancy Anne Null, Acting Director, Division of Legislation, at 245-8220.

Sincerely yours,

Henry R. Desmarais

Henry R. Desmarais, M.D.
Acting Administrator

Enclosures

Q. You have argued that marketplace forces will better serve beneficiary interests in constraining fees. Could you give us some information about the demonstrations, research, or evidence to date concerning the likelihood of maintaining quality and access as well as constraining costs?

A. There is evidence from our HMO demonstration program that its pro-competitive design resulted in reduced cost and improved access to Medicare beneficiaries. Over 300,000 Medicare beneficiaries enrolled in 32 HMO demonstrations up to April 1985. (At that time, the demonstrations became a part of the TEFRA HMO program.) The premiums charged to beneficiaries were less than an amount actuarially equivalent to the tradtional coinsurance and deductible amounts associated with fee-for service Medicare. They were also less than the premiums charged by traditional insurors for Medicare supplemental policies. In several instances there was no premium, yet beneficiaries received the usual Medicare benefits plus additional benefits such as prescription drugs, preventive care, eye examinations, and unlimited coverage of hospital care.

Based on survey results from HMO enrollees and fee-for-service beneficiaries, HMO enrollees reported that they were very satisfied with the choice they made in terms of access, quality of care, and cost. Overall 88-99 percent of enrollees reported that they were satisfied with the HMO they joined. This equalled or exceeded the percent of non-enrollees who reported they were satisfied with their current source of medical care. Enrollees

expressed more dissatisfaction with the fee-for-service system's access, quality of care and cost than non-enrollees did. Researchers at Johns Hopkins University have analyzed medical care services received in HMOs serving the non-Medicare population, and concluded that the quality of care is maintained and often improved in HMO settings.

In our research and evaluation agenda, we are going beyond beneficiary survey data to examine HMO data related to access, quality and cost. We will compare measures of access, quality, and cost in the HMO setting to those in the traditional fee-for-service system.

Q. What has happened in the participating physician program? How have participation rates varied by region? By specialty?

A. The overall participation rates, nationally and by region and specialty have not changed substantially between FY 1985 and FY 1986. In FY 1985, 30.4 percent of physicians signed Medicare participation agreements. In FY 1986, this number dropped slightly to 28.4 percent. Most States have had stable or slightly decreasing participation rates. However, in six States participation rates declined substantially.

In FY 1986, participation ranged from 21.7 percent to 37.8 percent. The highest rate was for cardiologists and the lowest, for anesthesiologists.

Q. Can you provide some additional insight on what is actually being billed, rather than what the Medicare program is actually paying? Specifically, what has happened to the beneficiary out-of-pocket costs for physician services? How do out-of-pocket costs vary by region? By specialty?

A. Beneficiary liability, as a percent of total payment for Part B covered services (including physician payments and payments for other medical services), has continued to decline over the last three years. In FY 1983, beneficiaries paid approximately 32.7 percent of all Part B liabilities, while in FY 1985, this figure had been reduced to 31.4 percent.

The deductible represented 7.6 percent of all Part B liabilities in FY 1983 and only 6.3 percent in FY 1985. Similarly, "reductions" on unassigned claims (i.e., the amount paid by beneficiaries on Medicare claims in which the physician does not accept assignment) totalled 8.3 of Part B spending in FY 1983 and only 7.9 percent in FY 1985.

Coinsurance payments rose slightly over this three year period. In FY 1983, coinsurance represented 16.8 percent of Part B spending for covered services. In FY 1985, this figures has risen to 17.1.

No data is currently available which would estimate beneficiary liability as it varies regionally or by specialty.

BEST AVAILABLE COPY

Q. In your view, how long do you think it might take to move toward the capitated option you have envisioned? And don't you believe it might be wise as an interim measure to not simply tinker with the current system, but make a more concerted effort at exploring other alternatives as well?

A. Clearly, capitation is not going to be achieved overnight. Congress took a first important step toward this goal with the enactment of permanent authority for risk basis contracts for HMOs and competitive medical plans (CMPs) in the Tax Equity and Fiscal Responsibility Act of 1982. The first TEFRA contracts were signed in April 1985 and today close to half a million beneficiaries are enrolled in these plans. In these organizations, even with our tight budget environment, beneficiaries are receiving additional benefits beyond those available to enrollees in fee-for-service at no or limited additional out of pocket cost. We are working toward having 25 percent of our beneficiaries enrolled in capitated settings by 1990.

The TEFRA approach, although a first step, is not all that is required. The Administration has proposed to build on the reforms enacted in TEFRA through a voluntary voucher program. Our proposal if enacted would:

- expand the pool of entities that could qualify for capitated payments by allowing indemnity insurers, as well as HMOs and CMPs, to provide

alternative coverage;

- o make enrollment in private plans more attractive to beneficiaries by allowing employers to combine the Medicare payment with their own premiums for annuitants to secure a uniform plan without duplicative coverage;

- o eliminate certain requiremnts in current law that are over-regulatory; such as the requirement that HMOs and CMPs offer the actual Medicare benefit package (subject to the test of actuarial equivalence of benefits, a plan would be free to restructure the Medicare benefit package.).

In addition to the voucher proposal, HCFA is exploring alternative approaches to capitation such as geographic capitation and employer-at-risk.

In arriving at the policy of pursuing capitation, we did explore other options. As I stated in my testimony, we found the other options lacking. We believe that capitation is the best means to increase competition and consumer choice in our health care system. In this way, we will be able to provide high quality services while controlling program costs.

In the meantime, we cannot allow Medicare to continue to grow without some incentives to control that growth. The regulatory proposals to refine physician reimbursement methods in the FY 1987 budget represent a targeted effort to reduce the rate of increase in spending. These proposals address an number of areas where current payments levels are either unjustified or where payment is for services that are not medically needed.

Q. How does capitation circumvent the problems you identified under physician DRG's, with respect to aligning hospital and physician incentives?

A. The financial incentives under a capitated system are very different from those which would exist under physician DRGs. Under physician DRGs, a closed-end, case-specific payment is made directly to the provider for each spell of illness. When a case-specific payment is made to the provider, there may be an incentive to reduce the level of care furnished to an individual beneficiary. Further, physician DRGs only apply to inpatient services, giving providers the incentive to fragment and shift services to the outpatient setting.

Under a capitated system, payment is made to a financial underwriter (e.g., an insurance company, HMO or CMP) who would assume the risk of insuring all beneficiaries for all covered services (both inpatient and outpatient). Therefore, while the underwriter has an incentive to offer less costly service options, there is also a strong incentive to keep beneficiaries healthy and prevent serious illness. Case-specific physician DRGs do not provide this incentive.

Q. Under a plan such as geographic capitation, what kind of mechanism do you envision to ensure that beneficiaries are adequately protected with regard to quality and access?

A. Under geographic capitation, the underwriter would offer a number of coverage alternatives to Medicare beneficiaries. However, geographic underwriters would be required to retain "traditional" Medicare coverage for those beneficiaries who do not choose a coverage alternative. Thus, beneficiaries would never be forced to accept an alternative benefit package.

Services provided to beneficiaries under a geographic capitation plan would be subject to the same quality review that is performed today for all beneficiaries. In regard to the alternative plans, it would be in the interest of the underwriter to ensure that the quality of services provided are at least on par with those provided under traditional Medicare in order to attract beneficiaries to enroll in these options. Disenrollment provisions which are currrently effective for TEFRA HMOs and CMPs would also apply to these coverage alternatives. Therefore, beneficiaries would be allowed to switch back to traditional Medicare if they were dissatisfied with the alternative plan.

Health Policy Center

hpc

January 27, 1986

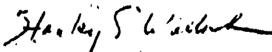
United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, DC 20510

Dear Ms. Salmon:

Enclosed please find responses to your questions of January 6, 1986 regarding testimony at 1985 Subcommittee on Health hearing on Medicare physician payment reform options.

If you have any questions, please feel free to contact me at (617) 647-2900.

Sincerely,



Stanley S. Wallack

SSW/ms
enclosure

Question #1 - Uniform Fee Schedule

It is not evident to me how much more predictability in expenditures consumers would gain from the introduction of a fee schedule. The reason for this relates to the thousands of procedures and, consequently, prices that would be encompassed by a fee schedule. With so many procedures, a visit could be classified in various ways. Visits also could be broken down into component parts or into a sequence of visits. Thus, I do not believe fee schedules should be supported because of their potential gain in predictability.

The attractive feature of the fee schedule is that it would provide the opportunity to realign physician payments --- across procedures, specialties and geographic areas. And, if assignment was mandated, Medicare beneficiaries would have a better idea of the cost they would incur. A physician fee schedule, with or without mandatory assignment, would alter the behavior of physicians. It is behavior changes that could increase utilization and, consequently, expenditures.

Question #2 - Capitation

A. It is because of the strong incentive to underserve that physician capitation may be preferable to full or traditional capitation programs. Prospective prices, whether DRGs or capitation payments, provide a very strong incentive for providers to do less since the provision of additional services reduces the net income of providers.

Selective data should be collected from all participating HMOs on utilization and outcome - so that access and quality problems can be identified. Comparative HMO data on ambulatory visits, ancillary services,

and admission rates by DRG would identify aberrant behavior, which could trigger on-site medical audits.

While monitoring quality is important, I believe we could gain more in the long-run by reducing the incentive (or cause) for underutilization. In my testimony, I spoke of partial capitation systems and how these would reduce the incentive to underserve. By having the government re-insure high cost individuals or by capitating for only part of the covered services, e.g. ambulatory care, providers would have less of a financial incentive to underserve. Since plans or providers would face less financial risk, they also may be willing to enroll individuals with a greater likelihood of needing health services.

Because physician capitation would place less risk on providers but still maintain an incentive to be efficient, I believe it may be preferable to traditional capitation programs.

Reductions in the Capitation Rate

I agree with you that all entities - insurers or providers - must be quite leery of entering into a long-run risk agreement with Medicare today. In light of Gram-Rudman and the necessary budget cuts, providers must be building their prediction of future Medicare payments into their decision. One likely business strategy is to require high profits from the outset of any new endeavor involving Medicare beneficiaries.

This real concern about being financially squeezed in the long-run could be addressed by altering the method by which capitation rates are established. If rates were negotiated or set in the market place rather than determined unilaterally by Medicare, providers would have more assurance of fair rates being established. These alternatives should be

pursued since the current method of establishing the capitation rate based on the fee-for-service sector must be altered in the long-run since we will not be able to use the fee-for-service sector must be altered in the long-run.

I believe a stable long-run pricing strategy would incorporate risk sharing between Medicare and the plans. By this I mean that if actual costs were lower than expected, both parties would gain. Conversely, if costs turned out to be greater than expected, both parties would do worse than they expected. By sharing risk, both parties have an incentive to establish a "fair price". For example, Medicare would have less of an incentive to set an inadequate premium because Medicare would end up absorbing some of the losses incurred.

In my testimony, I described the risk sharing capitation method incorporated in the Texas Medicaid program. This program requires both parties to estimate the likely per capita cost and negotiate a "pure premium" for services. A separate risk payment is also established with the state assuming most of the loss or gain from the established premium.

Entities Included Under Capitation

With regard to your question on which entity should receive the capitation payment, I believe that Medicare should capitate with providers or insurance sponsored plans as well as with insurers or carriers on a geographic basis. These are not mutually exclusive. The geographic or intermediary capitation program would allow a fee-for-service Medicare program to remain intact and I believe compete effectively with HMO plans.

Sicker Individuals

The government is probably paying more under the existing TEFRA HMO

program because sicker individuals are remaining disproportionately in the fee-for-service market. In a voluntary program, such as the TEFRA HMO program, the government pays more when favorable selection occurs. Since under a geographic capitation program all beneficiaries are included, the government would no longer bear the risk of favorable selection.

In a capitated, optional program that was based on vouchers or organized plans, the government would have to be concerned with the plight of sicker individuals. A subsidized risk pool is one answer. A better place to start may be with the AAPCC factors themselves. With the current payment formula, a plan is penalized for taking sicker patients. I would include a payment criteria for health status or chronic illness so that a plan gained by enrolling sicker individuals.

We must modify the current capitation program or formula so as to recognize the voluntary participatory basis of this program. HMOs decide whether or not to participate and have great latitude in determining whom to enroll. Only by creating the proper incentives can we bring about the desired results of lower costs and equal access.

Inclusion of Long-Term Care

o Long-term care must be financed so as to provide risk protection for individuals. The insuring of long-term care could be done through a public or private system. In either case, we should strive for some integration with the acute care system. The Social/HMO, which we developed at Brandeis, begins to fold long-term care into the capitated, acute care system. Early results of the program indicate that we can integrate chronic and acute care services and, thereby, take better care of the sick elderly in an efficient manner. The difficulty encountered in marketing the Social/HMO, which has a significantly higher premium than TEFRA HMOs because of the chronic care benefits, suggests that the difficulty of incorporating risk pooling for long-term care in a competitive market. One solution is to mandate the desired long-term care or chronic care services.

CENTER FOR HEALTH
ECONOMICS RESEARCH

824 Boylston Street
Chestnut Hill, MA 02167
(617) 738-0821

January 27, 1986

Ms. Shannon Salmon
United States Senate
Committee on Finance
Washington, D.C. 20510

Dear Shannon:

Enclosed are my responses to Senator Bradley's questions. If I can be of any further help, please do not hesitate to call.

Sincerely,

Janet B. Mitchell, Ph.D.
President

Enclosure

JBM/jm

Janet B. Mitchell, Ph.D.

1. Question

A uniform fee schedule would certainly improve the current situation because it would provide a degree of predictability to the system--for physicians and beneficiaries. But how will a fee schedule affect utilization?

Answer

We know from previous experience with the Economic Stabilization Program that price controls were accompanied with substantial increases in physician utilization. This, of course, is the fatal flaw of any fee regulation, including the current freeze on physician fees. It not only ignores the utilization side of the expenditure equation (total Part B outlays = fees * services), but actually encourages physicians to provide more services than before. If current service levels remain unchanged, a fee freeze represents a freeze in physician net incomes, and an actual reduction in real earnings over time, given inflation (and hence the incentive to increase utilization).

This is not <u>necessarily</u> the case with a fee schedule. While some physicians would experience reductions in reimbursement per service, others would actually enjoy an increase. So while fee schedules certainly do not help constrain volume increases, at least they do not engender across-the-board incentives for physicians to boost utilization. Fee schedules also have the advantage of appearing inherently more equitable to physicians: physicians who perform the same service are reimbursed the same amount, unlike the arbitrary differences produced by the UCR methodology.

Nevertheless, fee schedules can only serve as an interim solution to controlling physician expenditures. Over the long run, all physicians will share an incentive to increase utilization, especially in the face of heightened competition and an oversupply of physicians.

2. Question

The Administration seems to favor capitation as a method of paying for physician services. I am generally supportive of capitation as well--in theory. But I have some questions which are still unanswered:

- First, how do we ensure that the capitated payment, once established, would not be cut back to the point that quality of care would be affected? Ever since establishing hospital DRG's, we have squeezed reimbursement. Will the same thing happen with capitation for physician services?

Answer

When the hospital prospective payment system was enacted, it was always intended that the DRG payment would be rebased to incorporate the efficiency gains under the new system. It was assumed that considerable slack (inefficiency) existed in the hospital sector to permit these payment reductions. The validity of this assumption has

Answer (cont.)

been borne out by the record profits earned by hospitals in the past year. At some point, payment reductions may threaten quality of care, not because of inadequate funds but because of inappropriate provider response. The same would be true of capitation payment for physicians' services. It is up to you (Congress) to ensure that oversight groups like the PROs are adequately funded and that payment rates remain equitable. It is the responsibility of the research community to evaluate the effectiveness of the PROs and to help you determine what constitutes a fair payment rate.

Question

- Second, which entities--HMO's, insurance companies, preferred provider organizations--would be willing to take the risk to accept Medicare patients through a capitated payment? Insurers may be just as concerned as I am that the capitated payment--once established--would be cut back to the point that providers would be put in a bind.

Answer

Again, the willingness of insurors and other organizations to accept capitated payments will depend on the perceived fairness of the rate. Some stop-loss provisions may be required.

Answer (cont.)

There are several alternatives to capitation for physician services that would lower the potential financial risk, yet still achieve Part B cost savings. These include physician DRG payments for inpatient services as well as other packaging arrangements, such as special procedure packages. These were described in detail in my previous testimony before the Subcommittee. Such packages provide incentives for physicians to cut back on marginally necessary services, yet do not expose them to the potentially huge financial risks of capitation.

Question

- Third, since sicker patients will be less desirable to the HMO or insurance company, will these people be left out of the capitated system or be forced to pay significantly higher costs? If the capitated system is optional, would the people who opt out be forced into a high-risk pool with very high costs? And if this results, will the cost to government (through Medicaid and Medicare) rise?

Answer

Because of the large potential for cream-skimming, all insurors accepting capitated payments should be required to have an open enrollment period for Medicare beneficiaries. Otherwise, the government will enjoy the worst of both worlds, paying more than actuarially necessary for healthier capitated patients, while making fee for service payments on behalf of sicker patients.

Question

- Fourth, should we be examining ways to fold long-term care into a capitated system?

Answer

Yes, in the long run, a capitated system with more comprehensive benefits is socially desirable. Inclusion of long-term care could raise Medicare outlays dramatically, however, since these services are currently financed by Medicaid and by out-of-pocket payments from patients.

Boston University

Office of Academic Vice President
for Health Affairs
[illegible] Bay State Road
Boston, Massachusetts 02215
617 353 4520

January 28, 1986

Ms. Shannon Salmon
United States Senate
Committee on Finance
Washington, D.C. 20510

Dear Ms. Salmon:

Attached please find my responses to Senator Heinz's questions. The questions were sent to me as follow-up to my testimony at the December 6, 1985 Subcommittee on Health hearing on Medicare physician payment reform options. If any other committee members have questions, I would be happy to respond.

Sincerely yours,

Richard H. Egdahl

Richard H. Egdahl, M.D.
Director

RHE:sdc

Enclosure

DR. RICHARD H. EGDAHL'S RESPONSES TO SENATOR HEINZ'S QUESTIONS

SUBCOMMITTEE ON HEALTH HEARING ON

MEDICARE PHYSICIAN PAYMENT REFORM OPTIONS

December 6, 1985

Sen. Heinz Question #1: What is your opinion of the Administration's current Medicare risk-based HMO program?

It is difficult to think of HCFA's current activity with regard to HMOs as a program. As I understand it, the Administration is merely acting on authorization granted by a provision of TEFRA and negotiating at-risk contracts with HMOs and competitive medical plans (CMP). Aside from experimenting with the way Medicare organizes its financing, it is difficult to decipher the goal(s) of this so-called program.

With regard to HCFA's current HMO and CMP activity, three issues give me cause for concern. First, there is a danger of undercare. The elderly population is a group most subject to underservice especially if the "gatekeeper" is too parsimonious in his/her use of specialists and hospitalization. Currently, there are very few ways of detecting underservice. Instruments and systems for monitoring and reviewing adequacy of care outside the hospital need to be developed before it is safe to move completely to capitation.

DR. RICHARD H. EGDAHL'S RESPONSES TO SENATOR HEINZ'S QUESTIONS

SUBCOMMITTEE ON HEALTH HEARING ON

MEDICARE PHYSICIAN PAYMENT REFORM OPTIONS

December 6, 1985

Sen. Heinz Question #1 (Continued)

Secondly, there is the problem of adverse selection. Prepaid health plans need to minimize financial risk by enrolling a balanced mix of healthy and sick people. If too many sick people enroll and use a high volume of services, the plans will become unstable and may be forced out of business. Such instability would be particularly hard on an elderly population. On the other hand, if the plan is successful in minimizing adverse selection it may be more costly for Medicare in the long run. I question whether HCFA currently has the means and the will to determine appropriate payment levels for HMOs.

Thirdly, there is the matter of accountability. This is not unrelated to the issue of underservice. It is unclear, to date, how HCFA will know, in anything but gross measures, what they are getting from HMOs for their money. It may be helpful for HCFA to turn to industry and inquire about their experience with HMOs. Many large corporations have had considerable experience selecting, negotiating and working with a variety of prepaid health plans. Perhaps some lessons have been learned.

DR. RICHARD H. EGDAHL'S RESPONSES TO SENATOR HEINZ'S QUESTIONS
SUBCOMMITTEE ON HEALTH HEARING ON
MEDICARE PHYSICIAN PAYMENT REFORM OPTIONS
December 6, 1985

Sen. Heinz Question #2: What about the Administration's proposed capitation plan, especially its geographical capitation proposal?

To the degree that the Administration's proposed capitation plan includes HMO and CMP contracts it raises the same questions discussed above, i.e., risk of underservice, adverse selection and accountability. Geographic capitation introduces further complications. Prepaying the individual carriers for each beneficiary may eliminate fiscal uncertainty at the federal level but would shift the burden of determining the "best way" to pay for health services to the local or regional level. Such a shift may stimulate experimentation and demonstrations but, unless closely monitored, also carries with it confusion, instability, uncertainty for the beneficiaries, and potential inequities in the provision of benefits. The potential disadvantages of this kind of program need to be thought through very carefully.

Blue Cross
and
Blue Shield
Association

1709 New York Avenue, N W
Washington D C 20006
202 783 6222

March 4, 1986

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

Dear Ms. Salmon:

This is to respond for the record to Senator Dole's questions submitted in response to our December 6 testimony on Medicare physician payment reform options.

Enclosed are Senator Dole's questions and our responses. Please contact me if we may provide any additional information on this issue.

Sincerely,

Alan

Alan P. Spielman
Executive Washington Representative

APS:am

Enclosure

Blue Cross and Blue Shield Association
Response to Senator Dole's Questions
Submitted for the Record for
the Senate Finance Health Subcommittee
Hearing on Medicare Physician Payment Reform
December 6, 1985

Senator Dole: One of our concerns with the current payment system is that it is very difficult to establish what we are actually purchasing. For example, the most common changes are in the area of "patient visit". What type of suggestions do you have for us in order to develop a better definition of what is being purchased?

Response: We assume your question relates to the practice over the years of physicians "unbundling" services. As stated in our testimony, collapsing of procedure codes for related procedures would reduce incentives for physicians to fragment their billing for procedures and manipulate codes to increase their revenue. Medicare and many Blue Cross and Blue Shield Plans' private business lines use procedure coding and nomenclature referred to as Current Procedural Terminology, 4th edition (CPT-4) and HCFA's Common Procedure Coding System (HCPCS).

The current coding system and nomenclature provides overly discrete descriptions of many services. This situation leads to increased expenditures through coding misuse, confusion, "unbundling" of services and fee inflation. In some cases, for example, services like injections and blood pressure readings that were once paid for as part of a single examination fee can now be billed separately. Thus, we are concerned about the impact these coding systems can have on costs and utilization. The advisory committees that oversee the updating of these coding systems are acting to identify and modify coding and nomenclature by collapsing and refining certain problematic

surgical and other procedure codes. In this effort, the advantages of collapsing codes from a reimbursement standpoint must be balanced with the need for sufficiently detailed coding to permit close scrutiny of benefit use and physician practice patterns.

Senator Dole: Do you have any information concerning whether there has been an increase in the volume of services and, if so, in what areas has this occurred? Can you give some additional insights as to how we might better explain the wide variation in both price and volume now being observed in a number of procedures and practices?

Response: We assume that you are particularly interested in information concerning our private business and in Medicare information not available through public sources. We do not have any special data on Medicare. Further, we do not have comprehensive national survey data on Blue Cross and Blue Shield Plan experience with variations in the price and volume of specific procedures performed by physicians, or on geographic variations in price and volume. However, we do have anecdotal information on this issue.

A major change in recent years has been the shift from inpatient to outpatient procedures, particularly for surgeries. For example, with respect to data for annuitants under the Blue Cross and Blue Shield high-option Federal Employee Program, the volume of inpatient surgical services per 1,000 enrollees dropped 5% from 1983 to 1984, while the volume of outpatient surgical services increased 5%. However, variations in other types of services used by this population show no apparent pattern. For instance, from 1983 to 1984, the volume per 1,000 enrollees for x-rays and for lab services fell 5%, while volume for radiology services (professional component) and for inpatient medical services each increased by 10%.

From a policy perspective, the increased use of outpatient care, and corresponding decline of inpatient care, generally has been viewed as a positive development. However, the concurrent development of greater competition for professional revenues and the growing sophistication and complexity of ambulatory care delivery are creating circumstances that will require greater efforts in monitoring outpatient services and determining the sources of variations in the utilization and price of those services.

Finally, we support the need for additional research to explain the wide variations that do exist for price and volume. For this reason, we support establishment of a Physician Payment Review Commission as proposed in the Fiscal 1986 budget reconciliation bill.

AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 645-5000 • TWX 910-221-0300

JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

March 14, 1986

The Honorable Robert Dole
Committee on Finance
United States Senate
Washington, D.C. 20510

RE: Response to Additional Questions as a Follow-Up to Testimony Presented on December 6, 1985 to the Subcommittee on Health of the Senate Finance Committee Concerning Medicare Physician Payment Reform Options

Dear Senator Dole:

We are pleased to respond to your questions that were submitted to the American Medical Association as a follow-up to testimony presented on December 6, 1985 to the Subcommittee on Health of the Senate Finance Committee concerning Medicare physician payment reform options. Our replies to your questions are attached to this letter.

Sincerely,

James H. Sammons M.D.

James H. Sammons, M.D.

JHS/dap
2434p

Response to Additional Questions
Follow-Up to Testimony Presented on December 6, 1985
Subcommittee on Health of the Senate Finance Committee
RE: Medicare Physician Payment Reform Options

1. One of our concerns with the current payment system is that it is very difficult to establish what we are actually purchasing. For example, the most common changes are in the area of "patient visit." What type of suggestions do you have for us in order to develop a better definition of what is being purchased?

The American Medical Association shares your concerns with trying to determine what is actually being purchased by the Medicare program when it pays for a physician's service. To this end, the Association has been active in the development of and continual updating of the Physicians' Current Procedural Terminology. This work, commonly referred to as CPT-4 (4th edition), provides numeric codes for over 7,000 medical procedures. The AMA believes that utilization of CPT-4 is the most effective way to describe medical services.

CPT-4 has been accepted by the Health Care Financing Administration (HCFA) as the means for describing and coding medical procedures. CPT-4 is updated periodically by a panel of twelve physicians, including representatives from HCFA, the Blue Cross/Blue Shield Association, and the Health Insurance Association of America.

CPT-4 provides an accurate mechanism to differentiate among different services and different levels of physician services. For example, the question points out that the most common charges are in the area of "patient visits." An examination of CPT-4 shows that there are eleven possible codes to describe a patient visit in a physician's office. Proper use of CPT-4 coding should provide clear identification as to what is being purchased when a charge is made for a "patient

visit." Of course, the individual physician's record of the patient's visit should provide information supporting the coding decision based on his or her actual practice. We believe that use of CPT-4 allows the physician to act as the proper arbiter of the level of services provided. We do not believe it would be realistic for another entity to peruse the patient's confidential medical record to try and describe the level of services provided.

We do recognize that questions have been raised about the appropriate definition of services that are provided. While we believe that such definitions are adequately provided by CPT-4, it is clear from the many questions outstanding that a more accurate question is "whether the payment for services accurately reflects the physician's work product?". The AMA believes that there is a need to evaluate physician reimbursement under Medicare. To this end, the Association is working as a subcontractor with Harvard University on the development of a resource cost-based relative value study (RVS). Funds for the first year of this study have become available to the contractor from HCFA, and the study is now moving beyond the design stage. It is expected that this study will provide a basis for more equitable reimbursement for individual medical services.

2. Do you have any information concerning whether there has been an increase in the volume of services and, if so, in what areas has this occurred? Can you give us some additional insights as to how we might better explain the wide variation in both price and volume now being observed in a number of procedures and practices?

Beyond data generated by HCFA, the AMA does not have in-house information independently to identify particular stated increases in

the volume of services provided Medicare beneficiaries. It is generally recognized that the Medicare population is increasing, is living longer, and is thereby consuming an increasing proportion of medical services.

There is no doubt that variations do exist in both price and volume in a number of medical procedures and practices. While the extent of such variations may be questioned, we believe that variation is appropriate. Variations reflect legitimate differences in providing medical services among physicians and in the provision of those services to different patients. Each physician brings to his or her practice individual characteristics that reflect such factors as education and training, experience, skill, area wage rates, area business costs, professional liability costs, and a host of other factors. In addition, each patient seen by the physician presents variables reflecting individual factors such as age, sex, type of work performed, medical history, level of physical activity and physical condition, and stage of disease condition where illness is present.

It is inappropriate for government to apply variation analysis as a means to cut reimbursement levels based on the theory that the "least is always best." While the AMA recognizes that issues raised by geographic variations must be addressed, these issues must be approached using the medical model to assure the availability of the best quality care, and not from the strict view of cost cutting. To this end, state medical societies have worked to identify and address regional variations, and the AMA currently is working to develop programs to further aid state medical societies in examining area variations.

The AMA and other organizations are in the process of analyzing and acting on issues raised by such variations. We believe that variations should be examined with an eye toward the achievement of optimal rather than minimal levels of care based on a combination of both statistical analysis and clinical judgment. In addition, we believe that the development of the RVS, as noted above, will prove beneficial in variation analysis.

2434p

March 12, 1986

Honorable Robert Dole
Chairman
Senate Finance Committee
U.S. Senate
Washington, DC 20510

Dear Senator Dole:

1 The American Society of Internal Medicine (ASIM) appreciates the opportunity to respond
2 to your questions as a follow-up to our December 6 testimony to the Senate Finance
3 Committee on Payment for Physician Services under Medicare.
4
5 **Question 1:** One of our concerns with the current payment system is that it is
6 very difficult to establish what we are actually purchasing. For example, the most
7 common charges are in the area of "patient visit." What type of suggestions do you have
8 for us in order to develop a better definition of what is being purchased?
9
10 ASIM recognizes that there is considerable concern that the current "a la carte" billing
11 system (as described by Current Procedural Terminology) may create incentives for
12 fragmentation of services, overutilization, and upcoding of services to obtain higher
13 reimbursement. Some have suggested that many services which now are billed separately
14 could be "packaged" or "bundled" into a more broadly defined unit of payment. Janet
15 Mitchell of Health Economics Research, Inc., for example, has suggested that charges

american society of internal medicine
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1 for all ancillary services, such as laboratory tests and diagnostic procedures, could be
2 combined into a single payment for an "ambulatory patient encounter" (i.e. an encounter
3 in a physician's office).
4
5 ASIM recognizes that there is a need to review the existing units of definition in CPT-4
6 to determine whether or not some services could be combined without resulting in
7 undesirable changes in patient care. Our Board of Trustees recently initiated an effort
8 to review services in CPT-4 and to recommend appropriate ways to reduce the number of
9 services and/or to "package" certain diagnostic and surgical services. Although
10 completion of this program is expected to take several months, ASIM will be pleased to
11 share with you its recommendations as soon as they are available.
12
13 The Society has considerable concern, however, over the concept of including payment
14 for all diagnostic and ancillary services in a newly defined "ambulatory visit package."
15 As noted in the recent Office of Technology Assessment (OTA) report Payment for
16 Physician Services: Strategies for Medicare, packages of related services would create
17 "a financial incentive to refrain from using resources whenever possible and to use the
18 least expensive ancillary services, referral physicians, and, when applicable, facilities.
19 Mandatory assignment will be necessary with packaging to prevent providers from
20 passing that financial risk back to Medicare or on to the beneficiary by billing for
21 amounts in addition to the packaged rate. In contrast to the present situation, the
22 concern about quality of care within packages would be that services would be underused

1 or have inferior quality. Access could also be problematic if the variation in the cost of
2 treating expensive patients was not adequately reflected in the case-mix adjustment. In
3 that case, physicians might refuse to treat beneficiaries with complicated and possibly
4 expensive conditions."
5
6 ASIM shares the OTA's concern that packaging services in an ambulatory visit encounter
7 could result in inappropriate withholding of services to beneficiaries. Internists, in
8 particular, tend to treat older, sicker patients with more complex problems than
9 physicians in other specialties (a conclusion supported by DHHS' National Ambulatory
10 Medical Care Survey and other studies). Because of the case mix typically seen by
11 internists, internists on an average require a greater utilization of ancillary and
12 diagnostic procedures than physicians in many other specialties. Unless the more
13 complex case mix typical of internal medicine practice was adequately reflected in the
14 payment levels for an ambulatory visit package, strong incentives would be created for
15 internists to delay or withhold necessary ancillary services, to the detriment of patient
16 care. Similarly, individual patients with complex conditions might receive poor quality
17 care if the payment level for an encounter was inappropriately low. A situation might be
18 created that is analogous to that of hospitals that are prematurally discharging--or
19 withholding necessary services to--patients that, because of complex and costly

1 illnesses, represent a loss to the hospital given the amount of payment allowed for the
2 particular DRG category. Therefore, ASIM urges caution in mandating major changes in
3 definitions of services until adequate study is conducted on the effect of such changes on
4 patient care.
5
6 **Question 2:** Do you have any information concerning whether there has been an
7 increase in the volume of services and, if so, in what areas has this occurred? Can you
8 give some additional insights as to how we might better explain the wide variation in
9 both price and volume now being observed in a number of procedures and practices?
10
11 ASIM is concerned about unjustified variations in different localities in the utilization of
12 certain services, as well as hospitalization rates for given diagnoses, which cannot be
13 clearly explained or justified by differences in case mix. In some instances, such
14 geographic variations may be justifiable. For example, a community with the lowest
15 utilization patterns may not necessarily be providing as high quality of care as a more
16 expensive community. Differences in practice patterns might also be explained by the
17 availability of certain innovative forms of technology in some communities compared to
18 others. In general, however, ASIM is concerned that wide variations in practice patterns
19 in many instances may not be justifiable or necessary.
20

1 To address this problem, ASIM's Board of Trustees recently decided to:
2
3 1. Support the development of data systems that can generate adequate and
4 statistically valid data on geographic variations in practice patterns.
5
6 2. Support the concept that data collection and publication is the key to
7 educating internists and other physicians on variations in practice
8 patterns.
9
10 3. Explore with internal medicine subspecialty societies the possibility of
11 developing a collaborative project to share data on practice patterns with
12 internists.
13
14 As a result of these actions, ASIM will be committing a substantial amount of resources
15 to developing a program to disseminate data on variations in the use of services
16 performed by internists in different localities as a means to bringing about more
17 appropriate consistency in styles of practice. We anticipate that many of the
18 subspecialty societies of internal medicine share our interest in this area and would be
19 willing to collaborate on this project. ASIM will be glad to share with you more
20 information on this project as it is developed further.
21

Honorable Robert Dole
March 12, 1986
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1 ASIM also believes that geographic differentials in the fees for similar services may be
2 appropriate, but only to the extent that such differentials can be justified by legitimate
3 differences in the cost of practice in different parts of the country. Unless there are
4 clear differences in the cost of practice, such differentials cannot be justified.
5
6 For this reason, ASIM favors the development of a schedule of allowances based on a
7 resource cost relative value scale. Dollar conversion factors for such a relative value
8 scale should be adjusted by region to reflect only the legitimate differences in the cost
9 of practice in each region or locality. Once the initial schedule of allowances reflecting
10 appropriate practice cost differences is developed, it should be updated on an annual
11 basis to reflect changes in the cost of practice, according to a cost of practice index that
12 accurately measures by locality relative changes in current and future practice costs.
13 Conversion factors would be increased only to the extent that the cost of practice has
14 increased in a given locality.
15
16 The Society also believes that the "pro-technology" incentives in the existing payment
17 system is one of the major factors behind the steady increase in the volume of ancillary
18 and diagnostic services provided during a given patient encounter. As explained in
19 ASIM's December 6 testimony, the Society strongly supports the development of a
20

Honorable Robert Dole

March 12, 1986

Page 7

1 payment system that places relatively more emphasis on physicians' cognitive services

2 compared to procedural services.

3

4 ASIM appreciates the opportunity to share these thoughts with you. Please feel free to

5 call on us if we can be of further assistance.

6

7 Sincerely,

8 N. Thomas Connally, MD

9 N. Thomas Connally, MD

10 Chairman
Governmental Activities

/srl
G-BD-0217

American College of Cardiology

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December 20, 1985

Senator David Durenberger
Chairman, Health Subcommittee
on Finance
SD-219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

The American College of Cardiology (ACC), representing more than 14,000 physicians who are expert in the diagnosis and treatment of cardiovascular disease, would like the attached statement to be part of the record for the December 6, 1985 hearing on Medicare physician payment reform.

We look forward to working with the Subcommittee on this important issue in the near future.

Sincerely,

William W. Parmley

William W. Parmley, M.D., F.A.C.C.
President

WWP:bp

Statement to Senate Committee on Finance Subcommittee on Health on Physician Reimbursement Reform

The American College of Cardiology (ACC), representing more than 14,000 physicians who are expert in the diagnosis and treatment of cardiovascular disease, appreciates the opportunity to participate in the deliberations of the Subcommittee concerning reform of the Medicare physician payment system. We ask that this statement be made a part of the permanent record of the December 6, 1985 hearing of the Subcommittee on Health concerning Medicare physician payment.

The ACC generally agrees that the current Medicare reimbursement system for physicians is probably unnecessarily complex and inflationary. Accordingly, we acknowledge the need to reform the present system, and would like to offer the following comments about the major reform proposals under consideration.

Physician DRGs

One of the options under consideration is the payment of a fixed fee to the attending physician, based on the patient's diagnosis. This concept is the focus of a congressionally-mandated study by the Department of Health and Human Services (DHHS), the release of which is pending.

The ACC has serious concerns about the concept of M.D.-DRGs. In any system where "averages" are the standard of payment, the specialist with a disproportionate number of severely ill patients will inevitably bear a large financial burden. Unlike a hospital or other large administrative unit, an individual physician, particularly a specialist, does not ordinarily have a large enough case load to make up losses on individual cases.

We would suggest that any thought of imposing a DRG system on M.D. reimbursement is unfounded, especially when the results of the inpatient hospital DRG system are still unknown.

Capitation

It has been reported that the White House Cabinet Council on Domestic Policy has concluded that the Medicare physician reimbursement system should eventually be moved toward a completely capitated system.

We would urge that any capitated system allow true freedom of choice for patients in terms of selection of their physicians. We remain unconvinced that there is any wisdom whatever in the so-called "gatekeeper" concept, whereby a general

practitioner or a nurse given all responsibility for referring patients to specialists, and is actually given a financial disencentive to refer. The danger inherent in the gatekeeper concept is in allowing the least-trained member of the health care team to make important decisions about the course of treatment of diseases with which he may be unfamiliar as well as limited in ability to appropriately diagnose. Moreover, the financial disencentives to refer may result in crucial delays in the provision of care. Additionally, the difficulty, (and therefore the costs,) of diagnosing a disease, such as heart disease, are greatly increased when the provider is not expert in the area of medicine involved. Clearly, while the gatekeeper concept may appear cost-effective in the short run, it probably is just the opposite over the long run.

Relative Value Scales

As you are well aware, the Health Care Financing Administration has awarded a contract to Harvard University to develop a relative value scale, which would assign monetary values to various medical care based on the resources expended in providing it. We trust that the value of medical training, including specialty and subspecialty training would be factored into the RVS. The ACC fully intends to work with Harvard University through its subcontractor, the American Medical Association, in the development of the RVS. We urge the Congress to encourage HCFA to go forward with the RVS project expeditiously.

The American College of Cardiology appreciates the opportunity to share its initial views with the subcommittee, and looks forward to working with the Congress in the important effort to reform the Medicare physician reimbursement system.

American Nurses' Association, Inc.

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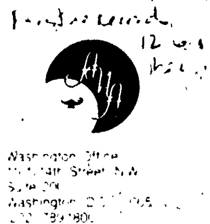


December 20, 1985

Senator David Durenberger
U.S. Senate
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

On December 6, 1985, the Senate Committee on Finance held a hearing on the issue of physician reimbursement. Because of the tremendous interest in this topic, no representatives of the non-physician practitioner community were able to appear as witnesses. We hope that the Committee will hold more extensive hearings on the issue of physician reimbursement in the future, and that representatives of other practitioner organizations with a strong interest in payment reform have an opportunity to present their concerns.

It is important to remember that when we discuss the issue of physician reimbursement, many practitioners other than physicians are also affected in various ways. In any such discussion, the impact on practitioners who work closely with physicians should also be considered. Changes in hospital reimbursement continue to affect those who work closely or do business with hospitals, and we would expect a similar outcome to occur as a result of changes in physician payment.

Specifically, we believe that changes in physician reimbursement policy affect the work of other health practitioners in the following ways:

1. Physician Supervised Services: Various health practitioners provide services in connection with physicians through their own practice, generally as employees. We believe that, in establishing the appropriate value of physician services, the contribution of other health professionals who work closely with these physicians must be taken into account. The value of nursing services, for example, should be an important part of this calculation when establishing the payment rate for physician services. Physicians use the professional services of nurses in a variety of ways, and these nursing practice patterns should be recognized when setting physician payment rates.

2. Direct Competition: A cornerstone of the current federal approach to controlling health care costs is a greater emphasis on competition. The lessening of price inflation in the health industry is due in large part to this new approach. Changes in physician payment policies should take into consideration the market value of those practitioners who compete with physicians, as well as those whose services regularly augment the medical care provided by physicians. In so far as possible, Congress should encourage the use of competitively priced alternative practitioners. Decisions regarding physician payment under Medicare should not ignore the potential contribution of other practitioners as substitutes for or as independent adjuncts to physicians.

3. "Medicalization" of Payment Policies: We are concerned that discussions of alternative physician payment policies overly characterize virtually all health services only as physician services, solely within the purview of doctors. We would urge the Committee to keep in mind that many Part B services are supplied by other health professions, and ought to be priced accordingly, whether or not they are supplied under the direct supervision of a physician. We hope that, in proposing any change in physician payment, the Committee will consult with the various non-physician health professionals in the design of appropriate payment reform.

We would appreciate the opportunity to present these and other concerns regarding physician reimbursement to the Committee for its consideration. We are aware that other practitioner organizations share similar concerns. Physicians are only one piece of the larger issue of physician reimbursement, and this issue is broader than compensation for physicians alone.

We appreciate your consideration of our interests.

Sincerely,

Eunice R. Cole, R.N.
President

association of american medical colleges

JOHN A D COOPER, M D, PH D
PRESIDENT

(202) 828-0460

December 20, 1985

The Honorable David Durenberger
Chairman, Subcommittee on Health
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Association of American Medical Colleges welcomes the opportunity to submit for the hearing record a written statement on Medicare payment for physician services. In addition to its medical school and teaching hospital members, the AAMC includes 82 faculty societies many of whose members provide professional medical services to Medicare beneficiaries.

The AAMC recognizes the present dissatisfaction and unrest with Medicare's usual, customary and prevailing system for determining payments for physician services. While the AAMC does not have a particular payment proposal to recommend, the Association must note that the form and content of any revised payment system for professional services will provide economic incentives that influence the attractiveness of the various specialties and subspecialties. Therefore, change in the payment system must be approached carefully and with demonstration projects so that intended benefits and unintended consequences are understood.

At the same time, the AAMC believes Congress should not continue to extend the physician fee freeze. Currently, fees for physician services are based on information submitted in 1982 with no adjustment provided for increasing practice costs such as the rapid rise in malpractice premiums. The AAMC strongly recommends halting the fee freeze on physician services.

As new approaches to physician payment ~~are considered~~ered, the AAMC urges careful attention to the application of the approach in teaching settings. For more than fifteen years, Medicare officials have been working with Congress and the AAMC to develop a fair and equitable application of the usual, customary, and prevailing system to physicians who involve residents in the care of their patients. The AAMC hopes that any changes in the payment system will address the teaching setting from the beginning. Therefore, the AAMC recommends that the following principles be included in any revised payment system:

- In a teaching setting, if the level of professional medical services provided a patient by the physician and documented in that patient's record is equivalent to the level of services furnished a patient in a non-teaching setting, then the physician in the teaching setting should be eligible for payment on the same basis as the non-teaching physician.

One Dupont Circle, N.W. Washington, D.C. 20036

The Honorable David Durenberger
Page 2
December 20, 1985

- Where a physician service in a teaching setting is eligible for payment, the payment for that service should be determined in the same manner and procedure as payments are determined for non-teaching physicians in the general medical community.

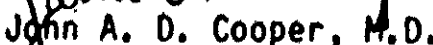
- The determination of the level of payments for professional services should not be influenced by the extent to which physicians provide services to non-paying or Medicaid patients.

- Payments for physicians choosing to practice in teaching settings should not impose requirements which result in artificial or atypical relationships on the provider organization and its medical staff.

Finally, the AAMC believes that special attention should be given to ensuring that any revised payment system does not preclude or discourage resident training in the full spectrum of long-term care and ambulatory care settings.

The AAMC appreciates your consideration of these concerns and recommendations and would welcome an opportunity to discuss them with you or your staff.

Sincerely,



John A. D. Cooper, M.D.