

Policy Analysis of Limiting Physicians' Fees

by

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TO: United States Representative Marilyn
Lloyd, Third Congressional District of
Tennessee, Democrat

FROM: Mr. David Barker, policy analyst for Ms.
Lloyd in her Chattanooga office

SUBJECT: The issue of capping physicians' fees in
regards to health care cost-containment

DATE: August 4, 1995

EXECUTIVE SUMMARY

As the health care debate comes to a climax, you will be asked to vote on a health reform bill within the month which will call for cost-containment through some form of limits on physicians' fees. The legislative history of physician fee-capping points both to caps' successes in bringing down prices (in the case of the recent Medicare reimbursement overhaul) and their failures in gaining popularity in Congress. The issue here is whether or not physicians' fees should be capped or whether a strategy of market reformation should be introduced. At present, there are no direct government-imposed limits on how much physicians can charge for their services; however, the Health Care Financing Administration (HCFA) has effectively regulated how much they will reimburse doctors for Medicare services according to their resource costs and to volume performance standards. Unfortunately, some Americans do not see this measure as enough in fighting "the spiralling costs of health care" and are looking for more demonstrative and direct methods for cutting the costs of health care in the private sector. There are two options presently coming out of committees that will make it to the floor within the month to try to appease this unsatisfied population: impose the same government-regulated caps that now apply to Medicare, or introduce medical savings accounts to induce a competitive market in health care. It is my recommendation that the medical savings account system is the best option available in the

current political climate, and I hope that you will make the same conclusion that I have.

PURPOSE

The health care debate began soon after President Clinton took office in 1993. He assigned First Lady Hillary Clinton to head a task force to write the Administration's health care reform bill. When the task force unveiled its bill last fall, health care reform became a major topic of conversation not only in Washington, D. C., but also in local communities around the country. For more than ten months, a battle for health care has been fought in the press, on television, and in public forums between both sides of the issue, and in the process approximately fifty million dollars has been spent campaigning—as much as was spent on the 1992 presidential race. And like that race, the health care issue now comes down to a vote, this time in Congress.

Before Congress's August recess, the health care bill will be brought to the floor, and you will be asked to vote on many different issues and amendments. One issue that is tantamount is that of capping physicians' fees as a method of containing health care costs. This report will recount past methods of Medicare fee schedules and analyze two methods of fee-capping. Your decision will affect many groups of Americans—not just doctors and patients, but also

insurance companies, government workers, hospitals—anyone with ties to the health care industry.

BACKGROUND

The United States government wholeheartedly and irreversibly became involved in health care when Congress passed Medicare and Medicaid legislation in 1965 under President Johnson. The Medicare legislation was the culmination of several years of public debate and fairly widespread sentiment towards reform, as is the case today. It was through Medicare and Medicaid that physicians' traditional means of charging patients was first challenged. Doctors could no longer charge everyone directly for their services; they now had to accept government reimbursements for treatment of their elderly or poor patients. Needless to say, the American Medical Association was not too happy with the government's meddling in their affairs and did not support the legislation.

However, neither Medicare nor Medicaid intended to change the current practice of medicine—at least not overtly. While they both provided financial resources for acute health care, within the original legislation there was a self-denying clause promising that "nothing in the Act would affect the practice of medicine" (Brandon 351). But there was no way for such a large sum of medical funding not to have some effect on the medical industry, and so the self-denying clause was basically a direct contradiction to the Act's intent.

It was included to make the bill more politically palatable to the AMA, President Johnson's most outspoken opponent.

The AMA did accept the Act and its intent not to disrupt doctors' present practices. In fact, doctors used the self-denying clause as an excuse to pump money into new technologies and focus on hospital-based specialty care, both of which drove up prices. This trend continued for nearly five years after the passage of Medicare and Medicaid, until the federal government took notice of the cost increases, realized its mistake, and began to impose cost-controlling measures (Brandon 351). But the government still reimbursed physicians for Medicare or Medicaid services primarily on a "usual, customary and reasonable" (UCR) basis for some twenty years.

In 1972, Congress created an economic index to be part of the Medicare payment system for physicians. The new amendment limited the growth rate of physicians' Medicare charges to the growth of general inflation. According to the statistics of the U. S. General Accounting Office, the limit was successful in controlling the growth, "result[ing] in a 36-percent increase in prevailing charge levels from fiscal 1973 through 1978" (Thompson 168). But while the growth of Medicare reimbursements slowed to match that of general inflation, the private costs went up. Since physicians no longer received the price they wanted from the government, they charged the patient's private insurance more to make up for the balance. This practice has become commonplace and is known as "balance billing." When Medicare changes its reimbursement rates, doctors change their balance billing to keep their actual charge level.

Physicians also increased their non-Medicare patients' charges to compensate for the index's decrease in revenues. This, too, was verified by a GAO study done in 1979. (Thompson 168).

Under the 1981 Omnibus Budget Reconciliation Act, states were given permission to try their own reimbursement methodologies as long as they met certain laws and standards for being reasonable and economically adequate. This time, however, the reimbursements were for Medicaid. The law required of the states that whatever cost-containment methods they tried, the payment rates must be sufficient enough "to ensure that individuals eligible for medical assistance have *reasonable access* to inpatient hospital services of adequate *quality*"(Fraser 308, italics added for emphasis). With this legislation, the government expressed its order of priorities in health care: access and quality above cost. According also to Section 1902(A)(30) of the Social Security Act, these payments must be consistent with quality of care. So while Congress wanted to contain health care costs, it did not want to sacrifice access and quality to do so.

During most of the 1980s, however, the issue of catastrophic coverage took center stage, and not much was done about physicians' charges. Then, in late 1989, Congress changed its Medicare Part B physician reimbursements again. Continually blamed for discouraging doctors from choosing primary care or serving in underserved areas, the UCR method (sometimes referred to as the "customary, prevailing, and reasonable" or "CPR" method) was no longer used as the primary standard for reimbursements. Instead,

"physicians would be reimbursed on the basis of the relative value of the resources expended in patient treatment" (Robins 389). The intent of the change was to increase rewards for primary care doctors and for preventive care procedures while decreasing those for surgeons performing acute care procedures. Although surgical societies vehemently opposed this revision, the AMA ultimately supported it, citing the bill's intent to more equitably distribute payments among its members (Robins 389).

For the past thirty years, the federal government has had the luxury of having Medicare and Medicaid as its guinea pigs for health care policies. Congress has tried many ways to strap down prices while trying not to hinder access and quality. The main lessons that can be learned from the Medicare and Medicaid experiences are that keeping costs, access, and quality in proper equilibrium is seemingly impossible; and that physicians are not going to let legislation that affects them pass without their having their say in the matter. The AMA has been a dominant special interest group since before Medicare's passage in 1965 and has grown larger in its influence as health care has taken over more and more of the American economy. Understandably, the AMA has in one way or another affected every revision of Medicare since it was passed.

All these changes in reimbursements affected Medicare and its elderly and disabled beneficiaries, but not the rest of the medical industry or the majority of Americans. Outside of Medicare, Congress has had some bad experiences in the past with price controls, namely in the 1970s. President Nixon effectively placed price caps on the

medical industry and much of the American economy in 1971. When the caps were finally removed, the prices for many services—including medical—increased rapidly. Many saw it as a natural reaction for the health care industry to try to recover what earnings they lost due to the price controls.

Then, as part of its National Health Insurance Bill, the Carter Administration wanted to limit

the amount that hospitals could receive from private insurers and government insurance programs. In 1979, with the memory of the Nixon controls still fresh, Congress killed Carter's hospital cost-containment proposal. (Rubin 2044)

The Congress is wary concerning the implementation of cost controls. But the very threat of revenue caps convinced the hospital industry to implement its own voluntary cost-containment plan, the "Voluntary Effort" (Litman 406). Perhaps physicians would respond the same way.

ISSUE

Should you support a bill that calls for imposing Medicare's cost-containment methods on private sector medicine or one that

calls for medical savings accounts to be formed to encourage natural competition among physicians?

PRESENT PRACTICE

Currently, the main cost-containment method that applies to physicians comes under the administration of Medicare. In order to curb the increasing charges that the federal government was having pay out to doctors, Congress created the Physician Payment Review Commission in 1986. The PPRC's initial charge was "to advise Congress on reform of the methods used by Medicare to pay physicians" (Lee et al 2382). Its task then enlarged in 1988 to suggest ways to slow down the increases in expenditures for physicians' services, after those rates rose to 15% a year. Following a year's evaluation of research, the Commission announced its recommendations in April, 1989:

To control growth in expenditures, the Commission propose[d] the use of expenditure targets, increased research on effectiveness of medical services, and development of practice guidelines. (Lee et al 2382)

The PPRC and its recommendations, after Congressional approval, are the current approaches to squelching doctors' fees for their services to Medicare beneficiaries.

The Commission, headed by two MDs and two PhDs, has replaced the "customary, prevailing, and reasonable" method with a fee schedule consisting of three main components:

1. a *relative value scale*(RVS), which indicates the value of each service or procedure relative to others;
2. a *conversion factor*, which translates the RVS into a fee for each service; and
3. a *geographic multiplier*, which indicates how payment for a service is to vary from one geographic area to another. (Lee et al 2382)

The relative value scale is the most important innovation among these three, the other two basically being extensions of it.

The RVS was the Commission's proposal to reimburse doctors for Medicare services based on those services' values in relation to other services. The PPRC's RVS contains several key aspects. For one, it is resource-based, bringing yet another acronym, RBRVS, or resource-based relative value scale. This means that payment is based on what the doctors themselves had to spend to perform the services—for instance, the cost of surgical tools, diagnostic machinery, or laboratory services. These practice costs are considered to be "resource-based" and reimbursable by Medicare.

A relative value scale also sets out a list of what a procedure or service is worth relative to others. If coronary artery bypass is a more complex and time-consuming operation than a tonsillectomy,

its relative value is higher. That abstract value is translated into real dollar amounts using the conversion factor, which is updated annually.

To determine the annual conversion factor updates, the PPRC uses

a national expenditure target for physicians' services under Part B.... The target [reflects] the increases in practice costs, growth in the number of enrollees, and a decision concerning the appropriate rate of increase in volume of services per enrollee. The last factor [reflects] trade-offs between beneficiary needs, technological advances, and affordability. (Lee et al 2384)

Also within the RVS are codes for surgical global services. This part of the strategy "determine[s] which services associated with an operation should be included in the global payment for surgery and which ones should be paid separately" (Lee et al 2382). In conjunction with a panel of surgeons and insurance representatives, the relative value of each operation has been tabulated.

The RVS controls costs by eliminating specialty differentials—"differences in payment to physicians of different specialties for the same procedure code" (Lee et al 2383). Specialists can no longer charge more for x-rays than primary care physicians for whimsical reasons such as enjoying a higher level of prestige. The PPRC believes that the best cost-containment method is simply reducing

the number of unnecessary and inappropriate services while not giving up access and quality. There is also a limit on balance billing.

It is important to remember that all of these cost-containment provisions only apply to Medicare and not to the private sector of medicine.

PROBLEM

It is common knowledge that physicians earn more money than the common American, even more than the common middle-class American. But data from the AMA on their salary increases is astonishing. "Physicians' average net income rose approximately 82% to \$177,400 in 1992 from \$97,700 in 1982" (Burda 44). General inflation and the growth rate of other salaries for this same period was approximately half of that. It is this kind of disproportionate growth that has caused a general consensus for fee containment to form.

Although the salary growth rates have slowed quite a bit recently, there is still a significant gap between middle-class salaries and those of physicians. As more and more doctors become employees of hospitals and managed care programs, their salaries are becoming more and more public. The recent onslaught of data on physicians' salaries has stirred up many people now calling for something drastic to be done.

According to the latest studies, radiologists are now averaging \$309,556 in salary by some estimates. General internists are making \$159,300 according to the AMA. And even family practitioners, the lowest on the physician salary scale, is now averaging \$111,800, again according to the AMA. (Burda 44-45).

Of course, to meet these higher salaries hospitals must pay more to the doctors, insurance companies must pay more to the hospitals, and the consumer must pay higher insurance premiums. Using this model of cost flow, many reformists cite physician salary reform as the cornerstone of cost-containment.

While there is cost-containment taking place in Medicare, there are currently no limits or even targets set on what physicians can charge the majority of Americans who have private insurance.

OPTIONS

There are two different options available to you at this time. Each option will have an impact or benefit on the groups of people affected, a cost of implementation, a level of administrative feasibility, and an inevitable political reaction by special interest groups.

- A. Apply the Medicare fee schedule to physicians' private practices.**

Expenditure targets would be established in each state, and if a state were in excess of target rates of growth, the Medicare payment schedule(the relative value scale) would be implemented in that state.

This option is advocated by House Majority Leader Gephardt and is part of his Democratic Health Reform Bill. Under his plan, a National Health Cost Commission would be formed to oversee the rate of growth in health care expenditures. By 2000, the Commission would recommend whether a system of private-sector cost-containment would go into effect the next year. The recommendation would be voted on by the Congress. If the Congress decided not to do otherwise, the Medicare payment plan would go into effect in the private sector of those states not meeting their expenditure targets. Doctors are given growth incentives to aim for their expenditure targets.

IMPACT: Certainly physicians' price rates would come down on state-wide levels as they tried to avoid government-imposed limits. Physicians, while not ecstatic, are more amiable towards targets than they are towards limits. If their payments were halved, doctors would *not* be able to see twice as many patients to compensate because of the imposed volume performance standard, which connects payment with patient volume. However, physicians, being the intelligent lot that they are, may find ways to circumvent the legislation and somehow charge enough to maintain their financial status. With this plan there is no market reason for them to lower

their prices—no threat of lost patients and no tax incentives—only mandatory limits to comply with.

Insurance premiums and hospital bill growth would decrease in the short run if the physicians' fees decreased. Their drop in payments to doctors would cause this. Hospitals would see less use of their expensive medical machinery as doctors cut down their costs. Insurance companies would have fewer claims to meet.

If doctor bills declined, it would be easier for people to go regularly for check-ups and at the onset of minor pains, thus emphasizing preventive care and preventing greater costs down the road.

COST: Creating a new National Health Cost Commission (NHCC) and all of its support staff would create another government bureaucracy to finance. As the government converts the private sector into a Medicare-style system, this Commission has the probability of growing bigger than the current HCFA. There would be more paperwork to do, more financial and service reports to file, and more bureaucrats to investigate physicians' practices.

ADMINISTRATIVE FEASIBILITY: The plan is feasible just as Medicare is feasible, but not without all the new agencies that the NHCC would have to create.

POLITICAL REACTION: The AMA would be upset for the financial loss of its members and for the practical nightmare of complying

with the system. The AHA and FAH (the hospitals) would be upset because the volume of services would decrease and they would have less money to spend on improving their facilities. The insurance industry would most likely support the plan as it would increase their profit margins. Consumer groups would certainly be pleased if prices came down, although they would not be happy if the quality of care deteriorated.

B. Introduce medical savings accounts to promote market competition among physicians.

Whereas competition keeps prices down within other industries, the health care industry does not respond to normal market forces in the normal way. Senator Gramm, a Texas Republican, advocates the use of medical savings accounts to drive down health care costs, including physicians' fees. The idea is to make patients more responsible for the payment of their health care so that they will be more cost-conscious. Under the current third party payer system, patients often don't realize how much they are paying their physician. If the patient were in charge of paying the physician, the idea is that they would demand lower prices from them like they would from any other service, and competitive doctors would respond by lowering their prices as a real market environment was established. The advocates of this system claim that it "promotes cost-consciousness and benefits those who practice it" (Gramm 57).

Employers would save money because instead of buying the most expensive employee policy to get the biggest tax break, they would pay into tax exempt medical savings accounts(MSA) for their employees. The employees could only use money from their MSAs for medical purposes. Whatever money remains in their MSAs at the end of the year, the employees can keep, thus providing the incentive for them to shop around for medical care.

IMPACT: If the economic incentives to providers work as predicted, the doctors again would not be happy with a salary cut; but they would rather reduce their rates themselves than have the government mandate them. For the consumer, shopping for a physician would be more like shopping for food, automobiles and shelter, according to Senator Gramm. Insurance rates would drop as a result of the market competition. Quality of care would stay the same if not improve as part of that competition. But there is no certainty that the health care industry would succumb to market forces even under these conditions. Health care is still a different type of demand than anything else on the economy. However, the strength of this plan is that it does address the major obstacles now in the way of a normal, competitive market for health care.

COST: The MSA plan would not cost anything more to employers. Insurance companies would experience a decline in the sales of their most expensive premiums but would see savings in their physician

payments. There is no new government bureaucracy formed here and no new paperwork.

ADMINISTRATIVE FEASIBILITY: The only things that needs implementation in this plan are the medical savings accounts themselves and their tax-exempt status. The rest of the plan is self-administered by the physicians and the businesses.

POLITICAL REACTION: The AMA would support this idea because it does not pose a threat to physicians' autonomy the way that fee limits do. The insurance industry would bless the plan, too, as it would not affect their profits. Big and small businesses alike would be pleased because most of their employees would be getting raises without the businesses having to spend any more money on them.

RECOMMENDATION

It is my recommendation that you support recommendation B, the medical savings account. There is no popular sentiment to limit car prices, house prices, or food prices because market competition naturally stifles them. If there were a way to impose the same market forces on the health care industry, we would certainly get the same results. If private medicine were under the same regulations as Medicare, it would lead to dangerously high levels of doctor dissatisfaction. When doctors take on Medicare patients and their

frustrating payment process, they have somewhere else to turn: their private patients. Option A would lead to the subtle transformation of all doctors into government employees. The relative value scale is a good system for a segment of the population but not for the entire country. In my opinion, the MSA plan would successfully introduce real market forces into the health care industry and physicians' fees would come down as a natural result of those forces.

DECISION BOX A B

Works Cited

- Brandon, William P. "Politics, Health and the Elderly: Inventing the Next Century—The Age of Aging." *Health Politics and Policy*. Ed. Theodor J. Litman and Leonard S. Robins. 2nd ed. Albany, NY: Delmar, 1991. 335-355.
- Fraser, Irene. "Health Policy and Access to Care." *Health Politics and Policy*. Ed. Theodor J. Litman and Leonard S. Robins. 2nd ed. Albany, NY: Delmar, 1991. 302-318.
- Gramm, Phil. "Why We Need Medical Savings Accounts." *The New England Journal of Medicine* 330.24 (1994): 3504-3507.
- Lee, Philip R., Paul B. Ginsburg, Lauren B. LeRoy, and Glenn T. Hammons. "The Physician Payment Review Commission Report to Congress." *The Journal of the American Medical Association* 261.16 (1989): 2382-2385.
- Litman, Theodor J. "Appendix." *Health Politics and Policy*. Ed. Theodor J. Litman and Leonard S. Robins. 2nd ed. Albany, NY: Delmar, 1991. 395-411.
- Robins, Leonard S. "Epilogue." *Health Politics and Policy*. Ed. Theodor J. Litman and Leonard S. Robins. 2nd ed. Albany, NY: Delmar, 1991. 387-394.
- Rubin, Alissa J. "Cost Containment Next Hurdle as Overhaul Moves to Floor." *Congressional Quarterly Weekly Report*. 23 July 1994: 2043-2045.
- Thompson, Frank J. *Health Policy and the Bureaucracy: Politics and Implementation*. Cambridge, Mass.: MIT Press, 1981.