

# EBRI issue brief

EMPLOYEE  
BENEFIT  
RESEARCH  
INSTITUTE

MARCH 1988 NUMBER SEVENTY-SIX



**Major change in the way Medicare does business with physicians inevitably affects the way physicians do business with other buyers, including employer health plans.**

## **Reforming Physician Payments: Medicare's Next Agenda**

Medicare's Supplementary Medical Insurance (SMI) is one of the fastest growing federal budget items: annual increases in the program have exceeded 14 percent in 8 of the last 9 years. Physicians' services are the largest component of SMI costs—representing nearly three-fourths of the dollar value of all claims submitted to SMI.

Medicare pays physicians for each service they provide based on the "customary, prevailing, and reasonable" charge for that service. Critics of this method of payment claim that it creates incentives for physicians to increase prices, provide more services than necessary to treat a given problem, and substitute expensive services when less costly ones might suffice. Despite recent legislative changes in the way physician payments are calculated, SMI costs have continued to rise.

These rising costs have led policymakers to seek fundamental reform in Medicare's payment method for physicians' services. Types of reform under discussion include adopting physician fee schedules; encouraging enrollment in capitation plans; and developing DRG-type physician payments, similar to Medicare's prospective payment system for hospital costs.

Reforming Medicare's system of physician payments has important implications for the entire health care market, including public and private insurers and employer health plans. Should Medicare adopt more stringent physician payment policies, privately insured patients might expect changes in the variety and scope of services available from physicians and potentially greater cost shifting from Medicare.

Weary of recent incremental measures and aware that physician service costs continue to rise, Congress may welcome a proposal from this or the next administration to enact major reform of Medicare physician payments.

## Introduction

Medicare Supplementary Medical Insurance (SMI), also called Medicare Part B, provides insurance coverage for physician services and outpatient medical care as well as some hospital services not paid by the Part A Hospital Insurance (HI) program. All people age 65 or older, people with end-stage renal (kidney) disease, and people who have received Social Security Disability Insurance benefits for two years or more are eligible to participate in SMI. Unlike HI, which is financed by payroll taxes levied on employers and current workers, SMI is financed by participant premiums and federal general revenues. By law, participant premiums must finance 25 percent of SMI annual costs for benefits and administration; as a result, the cost of SMI to participants rises with the increasing cost of the program.

SMI is the third largest domestic program in the federal budget (exceeded only by Social Security's cash benefits programs [OASDI] and Medicare HI) and is one of the fastest growing federal budget items. Annual increases in SMI expenditures have exceeded 14 percent for 8 of the last 9 years. By comparison, annual expenditure increases in the HI program stabilized at about 10 percent with the enactment of the Prospective Payment System (PPS) in 1983, and dropped to less than 5 percent in 1986 (table 1). Growth in participant premi-

ums, computed on a smaller base than either total program costs or federal outlays for SMI, has been much higher. Participant premiums are currently \$24.80 per month, an increase of nearly 39 percent over the 1987 premium and more than double the 1980 premium (chart 1).

The rising public cost of Medicare and the growing cost of health care to the elderly are issues that are likely to continue to propel changes in the Medicare program. The Reagan administration and Congress have addressed Medicare's inadequate coverage for hospital care among elderly persons without supplemental private coverage and the more widespread absence of any insurance for prescription drugs. Legislation that would expand Medicare coverage for these costs is expected to become law this year. The rising cost of physician care to both the government and the elderly, however, continues to concern public policymakers and is likely to engender legislative change in the way Medicare pays physicians.

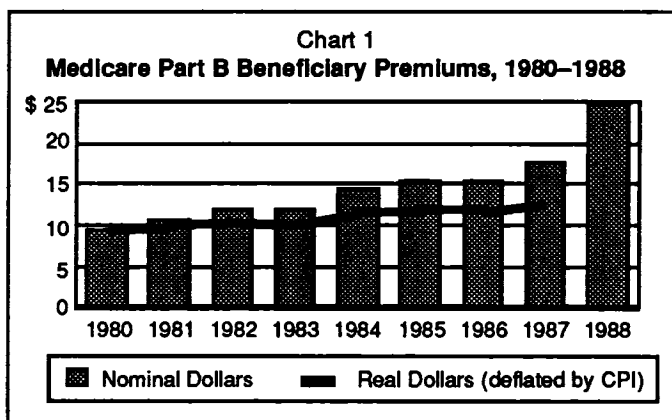
Medicare reform of physician payments has important implications for the entire health care market. As with hospital care, Medicare is the largest single buyer of physician care. In 1986, Medicare bought nearly 21 percent of all physician care delivered in the United States. Major change in the way Medicare does business with physicians inevitably affects the way physicians do business with other buyers, including employer health plans. Should Medicare adopt more stringent physician payment policies, privately insured patients might expect changes in the variety and scope of services available from physicians and potentially greater cost shifting from Medicare.

Physician payment reform by Medicare may also establish a precedent for payment reform by other public and private insurers. In the wake of Medicare's prospective payment for hospital services, 14 state Medicaid programs have adopted hospital payment systems based on Medicare's diagnosis related groups (DRGs). Historically, state Medicaid programs have paid physicians substantially less than they have charged, generating an access problem for many Medicaid beneficiaries and criticism that Medicaid has encouraged a different standard of practice for Medicaid patients. State Medicaid programs may be anxious

**Table 1**  
**Medicare Trust Funds Disbursements**  
**and Rate of Growth, 1977-1986**

	Hospital Insurance (HI) (billions)	Supplementary Medical Insurance (SMI) (billions)	HI Annual Change	SMI Annual Change
1977	\$15,737	\$6,038	—	—
1978	17,682	7,252	12.4%	20.1%
1979	20,623	8,708	16.6	20.1
1980	25,064	10,635	21.5	22.1
1981	30,342	13,113	21.1	23.3
1982	35,631	15,455	17.4	17.9
1983	39,337	18,106	10.4	17.2
1984	43,257	19,661	10.0	8.6
1985	47,580	22,947	10.0	16.7
1986	49,758	26,239	4.6	14.3

Source: *Report of the Board of Trustees of the Hospital Insurance Trust Fund, 1987*, and *Report of the Board of Trustees of the Supplementary Medical Insurance Trust Fund, 1987*.



to adopt physician payment reforms if they offer cost control as well as better access by beneficiaries to physician care.

Private insurers and self-insured employer plans may also seek to adopt some version of Medicare's changes in physician payment should they be enacted. Private insurance payments for physician services have grown faster than payments for hospital care over the last 15 years. Between 1970 and 1980, private insurance payments for physician care grew at an average annual rate of more than 15 percent, slightly faster than the 14.8 percent average annual growth in private insurance payments for hospital care. Since 1980, however, private insurance payments for physician services have grown at an average annual rate of nearly 12 percent, compared to 9 percent average growth in payments for hospital care. For the nonelderly population (who comprise most participants in employer plans), total private insurance payments for physician services rose at an average annual rate of 16 percent between 1977 and 1984, compared to 14 percent for their hospital care (Chollet, 1987).

This *Issue Brief* describes trends in SMI spending for physician services over the last decade and discusses possible implications of alternative proposals for physician payment reform within Medicare.

### ➤ Sources of Growing SMI Costs

Physicians' services are the largest component of SMI costs: claims for them represent nearly three-fourths of the dollar value of all claims submitted to SMI. Although physician services are not the fastest growing

source of SMI outlays, increased spending for physician services drives SMI costs. Between 1978 and 1982, physician services were responsible for nearly three-quarters of the increase in SMI costs. More recently, the percent of SMI cost increases attributable to the rising cost of physician care has tapered, dropping to 32 percent in 1985 (table 2). The slackening inflation in physician service costs under SMI, however, coincides with very rapid increases in other SMI costs.

SMI payments for both hospital outpatient services and independent lab services have grown markedly faster than payments for physician services in most years since 1974. Implementation of PPS has reduced hospitalization, but has increased the provision of outpatient services. This is most apparent in 1985, when SMI payments for outpatient services increased 79 percent, and accounted for more than half (57 percent) of the increase in total SMI provider payments. Between 1983 and 1985, hospital admissions (per population age 65 or older) and average length of hospital stays among the elderly both declined at an average annual rate of 3.3 percent (Prospective Payment Assessment Commission, 1987).

### Physician Payment under Medicare: Cost-Increasing Incentives

Critics of Medicare's manner of paying physicians have claimed that, like the private insurers' fee-for-service method of physician payment, it is inflationary. They claim that Medicare physician payment may create incentives for physicians to increase prices and to provide more services to treat a given problem. Furthermore, some argue that Medicare's payment system might encourage physicians to provide more complex and expensive services when alternative treatments may be equally effective (U.S. Congress, 1986).

Medicare pays physicians for each service they provide. Medicare's payment for a service is based on the "customary, prevailing, and reasonable" (CPR) charge for that service. Physicians bill either Medicare directly or the patient for services; Medicare then determines how much of that charge is "reasonable" and pays the physician (or reimburses the patient) accordingly.

The physician's charge for each service covered under Medicare is compared with customary, prevailing, and

**Table 2**  
**Reimbursements for Medicare Part B Services by Service Type and Average Annual Growth, 1974-1986**

	Total	Physician	Outpatient	Home	Independent Health <sup>a</sup>	Other Lab
Dollars in millions						
1974	\$ 3,183	\$ 2,678	\$ 304	\$ 38	\$ 26	\$ 138
1975	4,091	3,269	462	52	39	269
1976	4,554	3,497	585	84	48	339
1977	6,181	4,751	767	105	68	490
1978	6,617	4,932	909	121	71	584
1979	8,713	6,569	1,131	142	103	768
1980	10,245	7,562	1,421	181	117	965
1981	12,121	8,948	1,703	148	154	1,168
1982	14,983	11,092	2,151	23	188	1,528
1983	16,967	12,415	2,567	32	220	1,733
1984	17,738	13,073	2,659	35	253	1,717
1985	20,242	14,766	3,149	38	523	1,766
1986	24,584	16,161	5,631	36	672	2,084
Annual rate of growth						
1974-1975	28.5%	22.2%	52.0%	35.5%	51.1%	94.1%
1975-1976	11.3	7.0	26.7	62.8	22.6	26.2
1976-1977	35.7	35.9	31.1	24.7	40.5	44.5
1977-1978	7.0	3.8	18.5	14.8	4.4	19.2
1978-1979	31.7	33.2	24.3	17.9	45.7	31.4
1979-1980	17.6	15.1	25.6	26.8	14.1	25.7
1980-1981	18.3	18.3	19.9	-18.0	31.5	21.0
1981-1982	23.6	24.0	26.3	-84.3	21.7	30.9
1982-1983	13.2	11.9	19.3	39.4	17.4	13.4
1983-1984	4.5	5.3	3.6	7.5	14.8	-0.9
1984-1985	14.1	12.9	18.4	8.8	106.8	2.8
1985-1986	21.5	9.4	78.8	-4.2	28.5	18.0
Summary: average annual rate of growth						
1974-1978	20.1%	16.5%	31.5%	33.3%	28.4%	43.3%
1978-1982	22.7	22.5	24.0	-33.8	27.7	27.2
1982-1986	13.2	9.9	27.2	11.8	37.6	8.1
Proportion of change in spending for Part B services by service type						
1974-1975	100.0%	65.3%	17.4%	1.5%	1.5%	14.3%
1975-1976	100.0	49.2	26.6	7.0	1.9	15.2
1976-1977	100.0	77.1	11.2	1.3	1.2	9.3
1977-1978	100.0	41.5	32.6	3.6	0.7	21.6
1978-1979	100.0	78.1	10.6	1.0	1.5	8.8
1979-1980	100.0	64.8	18.9	2.5	0.9	12.9
1980-1981	100.0	73.9	15.0	-1.7	2.0	10.8
1981-1982	100.0	74.9	15.7	-4.4	1.2	12.6
1982-1983	100.0	66.7	20.9	0.5	1.6	10.3
1983-1984	100.0	85.4	12.0	0.3	4.2	-2.0
1984-1985	100.0	67.6	19.6	0.1	10.8	1.9
1985-1986	100.0	32.1	57.2	0.0	3.4	7.3
Summary: proportion of change in spending for Part B services by service type						
1974-1978	100.0%	65.7%	17.6%	2.4%	1.3%	13.0%
1978-1982	100.0	73.6	14.8	-1.2	1.4	11.3
1982-1986	100.0	52.8	36.2	0.1	5.0	5.8

Source: U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin* 9, table Q-14, September 1987.

<sup>a</sup> Between 1981 and 1982 the Omnibus Reconciliation Act of 1980 (P.L. 96-499) transferred payments for home health services from Part B to the Medicare Hospital Insurance (Part A) program, except for beneficiaries who are enrolled only in Part B.

reasonable charge limits to determine how much Medicare will pay for that service. Medicare carriers (private health insurance companies and Blue Cross and Blue Shield plans that handle Part B claims under contract to the Health Care Financing Administration

[HCFA]) calculate "customary" charges for each individual physician and "prevailing" charges among physicians practicing in the same region. The physician's customary charge is defined as his or her median charge for that service in the preceding year.

The prevailing charge is the 75th percentile of physicians' customary charges in a particular geographic area.<sup>1</sup>

### **Medicare's payment for a service is based on the "customary, prevailing, and reasonable" charge for that service.**

The "reasonable" charge is the least of (1) the physician's customary charge, (2) the regional prevailing charge, or (3) the actual billed charge. Medicare then pays 80 percent of the reasonable charge (assuming that the patient has already paid the \$75 annual deductible), leaving the beneficiary responsible for the remaining 20 percent coinsurance. If the physician has not agreed to accept Medicare payment as payment in full (that is, the physician does not accept "assignment"), the patient is also responsible for any difference between the reasonable charge and the physician's billed charge. An increase in a physician's billed charges raises that physician's customary charge in the subsequent year and is factored into the schedule of prevailing charges.

Beginning in 1976, the prevailing charge for each service could not exceed the 1973 prevailing charge, adjusted by the Medicare Economic Index (MEI). The MEI measures general inflation, earnings levels, and inflation in physician practice costs. Thus, in some regions the prevailing charge for a given service may be less than the 75th percentile of physicians' current actual charges. In this case, area physicians whose customary charges are relatively high face an administered price for the service.

Medicare's fee-for-service payment could encourage physicians not only to raise prices, but also to provide more care to Medicare patients. Indeed, between 1975 and 1985, the volume of services that physicians deliv-

ered per Medicare patient nearly doubled (U.S. Congress, 1987a). The large number of procedures that Medicare recognizes, some of which are distinguished by minimal technological differences, reinforces the incentive for physicians to deliver more care—billing Medicare for the most complex and expensive of a set of similar procedures, and billing separately for ancillary services such as laboratory tests that might otherwise have been included in the charge for an office visit (Sisk, et al., 1987). These incentives may be particularly strong for physicians with relatively high fixed production costs (expensive office space and equipment, for example), since Medicare may systematically pay them less than their cost of producing nontechnical care.

### **Other Sources of Growing Physician Service Costs**

Besides Medicare's payment incentives to increase costs, other factors have probably also contributed to rapid growth in the cost of physician care. These factors include the revision of Medicare's method of paying for hospital care as well as the recent much-publicized rise in malpractice insurance premiums. In addition, physicians may be achieving real increases in average net income.

### **Effects of Hospital Prospective Payment**

Medicare's prospective payment for hospital care—which provides a fixed price payment based on patient diagnosis—has altered the environment in which physicians practice medicine as well as the environment in which hospitals compete for patients. By shifting the site of delivery for many services to outpatient clinics and physicians' offices, hospitals have significantly reduced admissions and lengths of stay for Medicare patients. As a result, payments for physician services delivered in hospitals dropped from 61 percent of all SMI provider payments in 1982 to 50 percent in 1985 (Fisher, 1987). Because physicians may need to invest in new equipment to perform procedures on an ambulatory basis, they may be incurring increased capital costs for office equipment as well as additional costs for nurses and other trained personnel. Technological change enabling physicians to perform screening and diagnostic procedures and some surgeries in their offices has also contributed to declining hospitalization rates and rising ambulatory care costs.

<sup>1</sup> Carriers have discretion to define the geographic region within which prevailing charges are calculated, and may or may not calculate prevailing charges separately for specialist and general practice physicians, and for different types of specialists.

## Medical Malpractice Liability

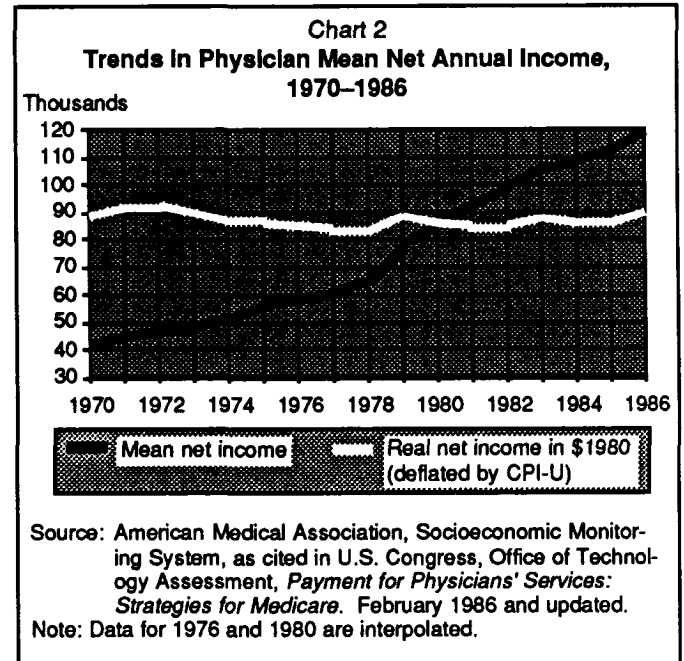
Growth in medical malpractice claims and insurance premiums probably raises the cost of physician care in several ways. First, physicians probably pass on the costs of higher insurance premiums directly in service prices. Second, growth in malpractice premiums may encourage physicians to practice "defensive medicine," performing more tests and procedures both to reduce the risk of a wrong or missed diagnosis and to establish a record to serve as a defense should the patient eventually sue for malpractice. Between 1983 and 1985, malpractice insurance costs for physicians doubled, rising from \$1.7 billion to \$3.4 billion (GAO, 1986). In 1984, malpractice insurance premiums were 7 percent of practice costs among self-employed physicians; in 1986, they reached 9 percent of practice costs.

## Physician Net Income

Despite higher practice costs, physicians' average real income net of practice costs has apparently grown in recent years, although they have not reached the high average net income levels reported in the early 1970s. Since 1980, real net physician income has remained generally stable (chart 2). However, 1986 data suggest that real net income among physicians rose more than 5 percent between 1985 and 1986. In 1986, the mean net income among physicians was \$119,500.

## Medicare Assignment and Participation: Recent Legislation

SMI allows physicians to accept or refuse "assignment" on each claim for services provided to Medicare enrollees. Physicians who accept assignment for a service bill Medicare directly for payment and accept Medicare's reasonable-charge reimbursement as payment in full. Physicians who do not accept assignment bill the patient for the service; the patient then seeks reimbursement from Medicare. Unassigned claims can be more costly for the enrollee, because Medicare pays only reasonable charges. If the physician's billed charge is higher than Medicare's reasonable-charge reimbursement, the patient is responsible for both the copayment and the difference between the physician's billed charge and the reasonable charge paid by Medicare. During the mid-1970s, the proportion of assigned Medicare charges fell, reaching a low of less than 48 percent in 1976. Since 1976, however,



assignment rates have risen, reaching 60 percent of charges in 1984, and almost 70 percent of charges in January 1987 (table 3).

The Deficit Reduction Act of 1984 (DEFRA) froze Medicare CPR payments for one year and established a Medicare participating physician program. Physicians who sign a "Medicare participation agreement" agree to accept assignment on all Medicare claims for one year.<sup>2</sup> DEFRA allowed participating physicians to increase their billed charges as they wished, with the prospect that those increases would be reflected in updating customary and prevailing charges when the freeze was lifted. Nonparticipating physicians were not allowed to increase their charges to Medicare enrollees at all. In October 1984, 30 percent of all physicians participated in Medicare; that rate has remained approximately the same through 1987 (McMenamin, 1987).

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) extended the freeze on nonparticipating physicians' actual charges and updated prevailing charges for physicians who had participated in

<sup>2</sup> Physicians must accept assignment on all services provided to Medicare enrollees that are also covered by Medicaid. In 1985, approximately 13 percent of elderly Medicare enrollees were also covered by Medicaid.

Table 3  
**Medicare Assignment Rates, 1968–1986**

Year	Percent of Claims Assigned	Percent of Charges Assigned
1968	59.0%	n/a
1969	61.5	n/a
1970	60.8	n/a
1971	58.5	53.8%
1972	54.9	50.3
1973	52.7	48.1
1974	51.9	47.8
1975	51.8	47.7
1976	50.5	47.6
1977	50.5	48.2
1978	50.6	49.6
1979	51.3	50.7
1980	51.5	51.7
1981	52.3	53.0
1982	53.0	54.2
1983	53.9	55.6
1984	59.0	59.6
1985	68.5	68.4
1986	68.0	69.5

Source: Health Care Financing Administration, as reported in Peter McMennamin, "Medicare Part B: Rising Assignment Rates, Rising Costs," *Inquiry* 24 (Winter 1987): 344-359.

Medicare in 1985. In updating prevailing charge levels, COBRA also established a permanent one-year lag between the prevailing charge levels of participating and nonparticipating physicians.

The Omnibus Budget Reconciliation Act of 1986 (OBRA86) allowed the freeze on nonparticipating physicians' charges to expire, but capped nonparticipating physicians' prevailing charges 4 percent below those of participating physicians. OBRA86 also acknowledged HCFA's authority to reduce prevailing charge levels for particular services, if HCFA determined those services to be overpriced relative to their resource cost. By administrative action, HCFA had reduced the prevailing charge levels for some surgical procedures, including cataract surgery.

Most recently, the Omnibus Budget Reconciliation Act of 1987 (OBRA87) froze prevailing charges for both participating and nonparticipating physicians through March of 1988. OBRA87 also capped the 1988 increase in participating physicians' prevailing charges to one percent; prevailing charges for specified primary care procedures (e.g., office visits) will rise 3.6 percent in

1988—the predicted increase in the Medicare Economic Index calculated by HCFA. OBRA87 capped the 1988 increase in nonparticipating physicians' prevailing charges at 0.5 percent; prevailing charges for primary care services provided by nonparticipating physicians are allowed to increase by 3.1 percent in 1988. OBRA87 again addressed the issue of "overpriced" services, reducing the prevailing charges for specific surgical procedures (including coronary artery bypass surgery and [again] cataract surgery) that were identified by the Physician Payment Review Commission (PPRC) as overvalued compared to a number of existing relative value schedules.

Over the last few years, four states have enacted legislation that requires physicians to accept Medicare assignment. In Massachusetts, physicians must accept assignment for all Medicare patients; in Rhode Island and Vermont, low-income Medicare patients' claims must be assigned; and in Connecticut, physicians must accept assignment for a minimum percentage of Medicare patients. The Supreme Court recently refused to consider the appeal of a federal court decision upholding the Massachusetts statute (*Massachusetts Medical Society v. Dukakis*, 484 U.S. (1987), cert. denied). This precedent may lead to similar legislation in other states.

The purpose of mandatory assignment laws is to assist the elderly, by limiting their out-of-pocket expenses for physician care. However, mandatory assignment together with Medicare payments that are below many physicians' production costs may impede the elderly's access to care if physicians avoid accepting Medicare patients. To date, no assessment has been made of whether enrollees' access to physician care is more difficult in states with mandatory assignment. Rhode Island, however, has established a commission to investigate the effect of mandatory assignment on access. The Rhode Island commission will report this year.

### Reforming Medicare's Payments for Physician Services

In each of the last four years, near-term budget considerations have driven federal legislation attempting to harness Medicare's payments for physician care. Weary of incremental measures and aware that Medicare's physician service costs continue to rise, Congress may

---

welcome a proposal from this or the next administration to enact long-term reform of physician payments. The apparent success of Medicare's prospective payment system for hospital charges in moderating growth in hospital expenditures under HI has attracted interest in a similar approach to controlling Medicare payments for physician services.

Discussion of physician payment reform in Medicare has focused on three areas: (1) developing physician fee schedules; (2) developing payments for episodes of care, analogous to Medicare's DRG-based payments to hospitals; and (3) capitation or prepayment, similar to Medicare's current fee arrangements with health maintenance organizations (HMOs).

#### Fee Schedules

Fee schedules for physician payments are typically based on a relative value scale. A relative value scale ranks individual services according to their complexity and the resources (time, training, and equipment) needed to produce them; each service type is assigned a numeric value. Insurance plans that use relative value scales (for example, many state workers' compensation plans) commonly negotiate relative values with physicians. The fee schedule is set by applying a dollar multiplier to the relative value scale; the same dollar multiplier applies to all service types. Physician payments can be adjusted by changing the dollar multiplier, rather than renegotiating the price of individual services.

Both the American Medical Association (AMA) and the PPRC have recommended that Medicare adopt a physician fee schedule using a relative value scale (PPRC, 1987). Fee schedules as described above preserve fee-for-service reimbursement and, therefore, compensate physicians in a way that is familiar.

A relative value fee schedule might have several advantages over the current Medicare reimbursement system. It could eliminate unjustified differences in physician charges for the same service within and across regions, producing differences in Medicare payments that would relate more closely to the cost of producing care. Under Medicare's current CPR reimbursement, differences in payments for the same service do not necessarily reflect differences in production costs.

A fee schedule would also allow Medicare to adjust existing relative prices that physicians charge for various services. Medicare's current CPR payments have been criticized for under-compensating primary care services that may involve substantial general practitioner time and over-compensating medical and surgical specialists for technologically sophisticated, complex procedures. By one estimate, Medicare overpays for 25 of 31 selected high-volume procedures relative to their estimated resource cost (Mitchell et al., 1987a). These 31 procedures account for one-fourth of all surgical procedures performed on Medicare patients. For 9 of these 31 procedures, Medicare pays more—and substantially more—than would be paid if payment were based on any of several existing relative value scales (U.S. Congress, 1987b). By increasing payments for primary care services relative to payments for technologically intensive services, Medicare might discourage physicians from "over-treating" Medicare patients.

However, a physician fee schedule would not necessarily encourage physicians to provide cost-effective care to enrollees; incentives for physicians to provide more services would remain. Regulatory controls to contain service volume could be difficult and administratively costly. Peer review organizations (PROs) review hospital admissions for Medicare and can deny payment for inappropriate admissions, but they have limited authority to review ambulatory care. While Medicare carriers have rudimentary systems to screen out patently fraudulent claims (for example, redundant procedures performed on the same patient), they have no protocols to verify whether the services that are billed were medically necessary. Third-party review of medical necessity is made even more difficult by the fact that many Medicare payments for physician services (nearly one-third) are for physician "visits," rather than for specific medical procedures (Juba, 1987).

OBRA87 requires the Secretary of Health and Human Services to develop a relative value scale and appropriate fee multiplier for radiology services (effective in 1989) and pathology services (effective in 1990). OBRA87 also requires that the Secretary develop a "relative value guide" for use by Medicare carriers in paying for anesthesia services.



## Payment for Episodes of Care

Paying physicians a fixed price for all services delivered during an episode of care, similar to Medicare's prospective hospital payment by patient diagnosis, would discourage physicians from providing unnecessary care. Such a system would have physicians bear the risk for more care, or more costly care, than the fixed price might reimburse.

Adapting current DRGs might be a relatively straightforward way of devising an episode-of-care payment system for physicians for inpatient services. However, in studying the possibility of DRG-type physician payments, Mitchell (1985) found that most physician charges vary widely within current DRGs; only surgical procedures were an exception. Developing units of payments for outpatient and ambulatory care services would require extensive data collection and analysis to determine appropriate units and payment rates. Furthermore, DRGs—developed for paying hospital costs associated with a specific diagnosis—may not appropriately describe the diagnostically vague situations that can confront physicians in office or clinic practice. Alternative units of payment might include: (1) procedure groups (potentially based on the AMA's current procedure terminology, CPT-4); (2) office visits, with some "case-mix" adjustment (e.g., diagnosis and whether the visit is for new symptoms or as a follow-up); and (3) inpatient condition units, or "physician DRGs" (Mitchell et al., 1987b).

Identifying an appropriate unit of payment, as well as an appropriate level of payment for each unit, is important for several reasons. When physicians risk not being compensated for all resources devoted to a patient, the patient may receive too little care. Alternatively, patients with symptoms or diagnoses that physicians cannot economically treat—given reimbursement constraints—may have difficulty obtaining care. Older, sicker patients or patients with complex diagnoses may be particularly vulnerable. However, if the unit of payment is not sufficiently comprehensive—truly describing a care episode—physicians have the opportunity to raise their incomes by providing more care per patient, as under Medicare's current method of payment.

The Reagan administration's proposed 1988 budget moved toward DRG-based physician payments for in-

hospital physician care, proposing to relate Medicare payments for inpatient radiologist, anesthesiologist, and pathologist services to the hospital DRG. Although hearings were held on the proposal, no formal legislation incorporating DRG-based payment for these specialties was introduced.

## Capitation

Under a capitation system, Medicare would pay physicians a fixed price per patient for any and all care provided to Medicare enrollees during a period of time, such as one year. Increasing the enrollment of publicly insured patients in capitation plans (specifically, in HMOs) has been a goal of the Reagan administration, which believes that capitation could contain hospital and physician costs in public insurance plans.

Medicare has some experience with capitation: the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) allows Medicare enrollees to voluntarily enroll in HMOs and competitive medical plans (CMPs) that contract with Medicare.<sup>3</sup> For each enrollee, Medicare pays the HMO a fixed amount based on expected aggregate Medicare costs for all enrollees in each county that the HMO serves. The HMO may charge Medicare enrollees an additional premium at the time of enrollment to reflect the cost sharing implicit in Medicare's payment as well as HMO services that Medicare does not cover.

In January 1988, nearly one million Medicare enrollees participated in 133 HMOs (HCFA, 1988). However, about 36 HMOs that contracted with Medicare in 1987 did not renew their contracts (called "risk contracts") for 1988. The relatively small Medicare enrollment (fewer than 1,500) reported by most HMOs that failed to renew suggests that Medicare's current capitation

<sup>3</sup> Before TEFRA, Medicare enrollees could participate in HMOs in several ways. Most commonly, Medicare reimbursed HMO costs for serving Medicare enrollees within Medicare's limits on covered services. The Social Security Amendments of 1972 (P.L. 92-603) also authorized HMO risk-sharing contracts with Medicare. (These contracts are now called pre-TEFRA risk contracts.) The unfavorable conditions of pre-TEFRA risk contracts, however, discouraged HMOs from entering into them; by June 1984, only one plan (Group Health Cooperative of Puget Sound) had signed a risk-sharing contract with Medicare (U.S. Congress, 1986). Finally, Medicare enrollees could also participate in HMOs for supplemental (Medigap) benefits not covered by Medicare.

---

payment may be adequate only for relatively large HMOs that can achieve a dispersion of risk.

Some HMOs pay physicians associated with the HMO on a capitation basis—an estimated 46 percent, according to a recent study. In these cases the physician receives a monthly allowance for patients that are HMO members and then assumes all or part of the risk for any services that they require. Most HMOs (81 percent) that use this method of payment are either individual practice associations (IPAs) or network HMOs (Hillman, 1987). In December 1986, nearly one half (48 percent) of all HMOs with Medicare risk contracts were IPAs (Iversen and Polich, 1987). Although no available data indicate how many of these IPAs pay physicians on a capitation basis, it is likely that some physicians associated with Medicare-contract HMOs are accepting capitation for Medicare patients.

The relatively large size of HMOs that have undertaken and renewed Medicare contracts suggests that capitation of all Medicare payment could present serious problems for both providers and patients. Individual physicians are unlikely to have enough Medicare patients to diversify the risk associated with capitation payments within their Medicare case loads. Instead, physicians could limit their risk by limiting the number of Medicare patients that they accept. Consequently, many patients might have difficulty finding a physician to care for them.

Although capitation is likely to remain a secondary form of Medicare payment for physician services, it is nonetheless likely to grow. The growth of Medicare enrollment in HMOs since April 1985, when the first risk contracts were signed, has been significant. Despite the well-publicized mismanagement of Medicare risk contracting in the case of one large Florida HMO, HMO participation among Medicare enrollees may continue to grow as workers with more experience participating in HMOs retire. Dr. Otis Bowen, secretary of the Department of Health and Human Services, has also encouraged corporations that provide retiree health insurance benefits to accept capitation of Medicare benefits. OBRA87 authorized HCFA to contract with three "Medicare insured groups" (MIGs) as demonstration projects, restricting the size of the demonstrations by capping the dollar amount of Medicare's payments

to each; to date, two such groups have contracted with Medicare to accept capitation under a Medicare waiver.

## ◆ Conclusion

Medicare's CPR system of payments for physician services may encourage physicians to provide patients with more care at higher prices. Recent legislation has made various changes in the way CPR payments are calculated, producing Medicare payments for physician care that do not necessarily cover production costs and may affect beneficiaries' access to care. Despite these efforts, SMI costs have continued to rise. Frustration with rising SMI costs may lead the administration and Congress to develop more fundamental long-term reform of physician payments.

Several types of reform are under discussion, including (1) adopting physician fee schedules; (2) developing DRG-type payments for episodes of physician care; and (3) encouraging enrollment in capitation plans. Adopting a physician fee schedule (possibly with adjustments to reflect regional cost differences) is probably the simplest of these to implement. A fee schedule may help to control expenditures by controlling prices; in addition, a fee schedule might reduce Medicare's current incentives for physicians to provide complex and costly forms of care. However, a fee schedule would retain Medicare's current fee-for-service incentive to increase Medicare payments by raising the number of services provided to each patient.

Alternative proposed reforms—episode-of-care payments and capitation—also present difficulties, however. Developing appropriate payment rates for episode-of-care payments would require substantial additional research; Medicare's current DRGs are especially inadequate as a basis for paying for care outside of a hospital setting. Although participation of Medicare enrollees in capitation plans may continue to rise, universal capitation may not be practical in areas where small, independent physician practices prevail. In such areas, capitation could impede enrollees' access to physician care.

Pending federal legislation that would finance expanded Medicare benefits with higher enrollee premiums suggests some of the guidelines that may govern

physician payment reform. In particular, federal legislators may be willing to raise SMI enrollee costs—at least among higher-income enrollees—to maintain access and quality. Nevertheless, the ability of enrollees to anticipate and budget their health care costs is an issue, one that is served by capping enrollee liability and raising premiums rather than increasing cost-sharing. Recent state legislation mandating that physicians accept Medicare assignment for some or all SMI enrollees reflects growing concern in various sectors that the elderly be able to budget and limit out-of-pocket health care costs.

Access to physician care and the quality of care provided to Medicare enrollees will be important factors in any reform of physician payment. However, balancing these concerns—access, quality, program costs, and enrollee costs—becomes increasingly difficult as federal budget constraints tighten.

For employers and other buyers of health care, the implications of reforming physician payment under Medicare are substantial. As with Medicare's reform of hospital payments, change in the way that Medicare pays physicians is likely to affect all buyers in the market by changing the way that physicians produce services. Employers that provide retiree health benefits may be particularly affected, since payment for physician care represents a large share—possibly most—of the cost of these plans. For these reasons, the coming debate over reforming the way Medicare pays physicians is likely to capture wide attention, not only from providers but also from employers and private insurers participating with Medicare in the same health care market.

## References

- Anderson, Gerard F., and Jane E. Erickson. "National Medical Care Spending." *Health Affairs* 6 (Fall 1987): 96-104.
- Anderson, Maren, and Peter D. Fox. "Lessons from Medicaid Managed Care." *Health Affairs* 6 (Spring 1987): 71-86.
- Chollet, Deborah. "Quality of Care as a Constraint on Cost Containment in the Private Sector." Presentation at the annual meeting of the American Public Health Association. New Orleans, LA. October 20, 1987.
- Fisher, Charles R. "Impact of the Prospective Payment System on Physician Charges Under Medicare." *Health Care Financing Review* 8 (Summer 1987): 101-103.
- Hillman, A.L. "Financial Incentives for Physicians in HMOs." *The New England Journal of Medicine* 317 (December 31, 1987): 1743-48.
- Iversen, L.H., and C.L. Polich. *1986 December Update of Medicare Enrollment in HMOs*. Excelsior, MN: InterStudy, July 1987.
- Juba, David A. "Medicare Physician Fee Schedules: Issues and Evidence from South Carolina." *Health Care Financing Review* 8 (Spring 1987): 57-67.
- McMenamin, Peter. "Medicare Part B: Rising Assignment Rates, Rising Costs." *Inquiry* 24 (Winter 1987): 344-359.
- Mitchell, Janet B. "Physician DRGs." *New England Journal of Medicine* 313 (September 12, 1985): 670-675.
- Mitchell, Janet B., William B. Stason, Kathleen A. Calore, Marc P. Freiman, and Helene T. Hewes. "Are Some Surgical Procedures Overpaid?" *Health Affairs* 6 (Summer 1987a): 121-131.
- Mitchell, Janet B., Jerry Cromwell, Kathleen A. Calore, and William B. Stason. "Packaging Physician Services: Alternative Approaches to Medicare Part B Reimbursement." *Inquiry* 24 (Winter 1987b): 324-343.
- Physician Payment Review Commission. *Medicare Physician Payment: An Agenda for Reform*. Annual report to Congress. Washington, DC: U.S. Government Printing Office. 1987.
- Prospective Payment Assessment Commission. *Technical Appendixes to the Report and Recommendations to the Secretary, U.S. Department of Health and Human Services*. Appendix A. Washington, DC: U.S. Government Printing Office. 1987.
- Sisk, Jane E., Peter McMenamin, Gloria Ruby, and Ellen S. Smith. "An Analysis of Methods to Reform Medicare Payment for Physician Services." *Inquiry* 24 (Spring 1987): 36-47.
- U.S. Congress. House. Committee on Ways and Means. Testimony of Philip R. Lee, M.D., chairman, Physician Payment Review Commission: Hearing before the Subcommittee on Health. 100th Cong., 2d sess., 15 June 1987b.
- \_\_\_\_\_. Committee on Ways and Means. Testimony of John M. Eisenberg, M.D., commissioner, Physician Payment Review Commission: Hearing before the Committee on Ways and Means. 100th Cong. 1st sess., 30 September 1987a.
- U.S. Congress. Office of Technology Assessment. *Payment for Physician Services: Strategies for Medicare*. OTA-H-294. Washington, DC: U.S. Government Printing Office, February 1986.
- U.S. Department of Health and Human Services. Board of Trustees, Federal Supplementary Medical Insurance Trust Fund. *1987 Annual Report*. Washington, DC: U.S. Government Printing Office, March 30, 1987.
- \_\_\_\_\_. Health Care Financing Administration. *Monthly Report of the Private Health Plan Option Operational Report*. January 12, 1988.
- U.S. General Accounting Office. *Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals*. GAO/HRD-86-112. September 1986.

---

**T**he Employee Benefit Research Institute (EBRI) is a nonprofit, nonpartisan, public policy research organization based in Washington, DC. Established in 1978, EBRI provides educational and research materials to employers, employees, retired workers, public officials, members of the press, academics, and the general public. The Employee Benefit Research Institute Education and Research Fund (EBRI-ERF) is a nonprofit, nonpartisan education and research organization established by EBRI in 1979. EBRI-ERF produces and distributes a wide range of educational publications concerning health, welfare, and retirement policies. Through their books, policy forums, and monthly subscription service, EBRI and EBRI-ERF contribute to the formulation of effective and responsible health, welfare, and retirement policies. EBRI and EBRI-ERF have—and seek—a broad base of support among interested individuals and organizations, as well as among private-sector companies with interests in employee benefits education, research, and public policy.

*EBRI Issue Brief* and *Employee Benefit Notes* ( a monthly newsletter featuring the latest news on legislation, corporate trends, statistics, events, and reviews in the field of employee benefits) are published by the Employee Benefit Research Institute Education and Research Fund with the assistance of the staff of the Employee Benefit Research Institute. For information concerning periodical subscriptions or other publications, contact EBRI-ERF Publications, 2121 K Street, NW, Suite 600, Washington, DC 20037-2121, (202) 659-0670.

Nothing herein is to be construed as necessarily reflecting the views of the Employee Benefit Research Institute or the Employee Benefit Research Institute Education and Research Fund or as an attempt to aid or hinder the passage of any bill pending before Congress.

© 1988. Employee Benefit Research Institute. All rights reserved. ISSN: 0887-137X

\_\_\_\_\_ is registered in the U.S. Patent and Trademark Office.  
\_\_\_\_\_