

# Issue Brief

Order Code IB85007

MEDICARE: PHYSICIAN PAYMENTS

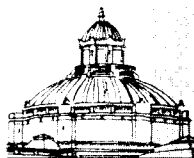
UPDATED 06/24/87

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## ISSUE DEFINITION

Medicare's expenditures for physician services increased at an average annual rate of 20.6% over the 1979-1983 period. As an interim measure to control escalating costs, Congress in 1984 approved a temporary freeze on physicians' fees under the program. The freeze period was extended for so-called nonparticipating physicians through Dec. 31, 1986, and lifted for participating physicians effective May 1, 1986.

On Oct. 21, 1986, the President signed into law the Omnibus Budget Reconciliation Act of 1986 (P.L.99-509). This measure contains a number of amendments to Medicare's physician payment provisions. It establishes procedures for setting payment limitations based on so-called "inherent reasonableness" criteria and provides for a reduction in physician payments for cataract surgery. Further, the law establishes additional incentives for physicians to become participating physicians.

On Jan. 5, 1987, the President transmitted the proposed FY88 budget which included several proposed modifications to physician payment provisions. Total savings attributable to these provisions were estimated at \$200 million in FY88.

## BACKGROUND AND POLICY ANALYSIS

Part I of this report describes how Medicare pays physicians. Part II summarizes recent legislation affecting physician payments, including the Deficit Reduction Act of 1984 (DEFRA) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Omnibus Budget Reconciliation Act of 1986 (OBRA). Part III (OBRA) outlines OBRA implementation issues. Part IV summarizes the relevant proposals in the President's budget. Part V outlines the issues which have been identified with the current payment system. Part VI outlines reform options. Part VII lists congressionally mandated reports.

### I. CURRENT PROGRAM

#### A. Description of Medicare Part B

Medicare is a nationwide health insurance program for 29 million aged and nearly 3 million disabled individuals. The program consists of two separate but complimentary types of health insurance. Part A, the Hospital Insurance Program, provides protection against hospital and related institutional costs. Part B, the Supplementary Medical Insurance Program, covers physician services and a range of other health services including outpatient hospital services, physical therapy, diagnostic and x-ray services, and durable medical equipment.

Total Medicare outlays were \$75.9 billion in FY86; of this amount \$49.7 billion were Part A outlays and \$26.2 billion were Part B outlays. Of Part B

outlays, 72% (75% of Part B expenditures for services) represented payments for physician services (\$18.8 billion). Approximately 6% of this figure represents payments for durable medical equipment. The Administration estimates that, in the absence of legislation payments for physicians' services will total \$23.8 billion in FY88 (70% of Part B outlays, 72% of Part B benefit payments, and 27% of total Medicare outlays). Medicare payments represented 18% of all physicians' incomes in 1982.

Part B is financed jointly through monthly premium charges on enrollees (\$17.90 in 1987) and from general revenues of the Treasury. The premium amount is updated every January 1. For the 5-year period beginning Jan. 1, 1984, enrollee premiums must equal 25% of the estimated cost of coverage for the aged. (The same premiums are paid by the disabled though per capita expenditures for this group are higher.) Federal general revenues finance benefit payments and administrative costs not financed through premiums.

Physicians' services covered by Medicare include those provided by doctors of medicine and osteopathy, wherever furnished, including those in the office, home, hospitals and other institutions. 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).

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

Five specialties -- internal medicine, general surgery, radiology, ophthalmology, and general practice -- account for over half of Medicare physician spending. Internal medicine alone accounts for 20%.

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

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

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. Definition of "Reasonable" or "Approved" Charges

Medicare pays for physician services on the basis of "reasonable charges." Recently, HCFA has begun calling these charges "approved charges." A reasonable or approved 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" 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 which are usually political or economic subdivisions of a State. There are 225 localities nationwide.

Prior to 1984, customary and prevailing charge fee screens (i.e., benchmarks against which individual charges are compared) were updated every July 1. The annual update in the prevailing charge screens was subject to an economic index limitation. This limitation (expressed as a maximum allowable percentage increase) is tied to an economic index known as the Medicare Economic Index (MEI), which reflects changes in operating expenses of physicians and in earning levels.

Because the Deficit Reduction Act of 1984 (DEFRA) froze physicians' fees through Sept. 30, 1985, the annual increases in the customary and prevailing charge screens otherwise slated for July 1, 1984, did not occur. Subsequent fee screen updates were slated to occur on October 1 of future years beginning in 1985. However, the increase slated to occur on Oct. 1, 1985, was postponed by the Temporary Extension Act of 1985 (P.L. 99-107, as amended) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, the next update occurred on May 1, 1986, for participating physicians only. Future updates for all physicians will occur on Jan. 1 of each year beginning in 1987. Prevailing charges applicable for nonparticipating physicians will continue to be less than for participating physicians.

#### C. =Definition of "Assignment"

Medicare payments are made either directly to the doctor or to the patient depending upon whether the physician has accepted assignment for the claim. In the case of assigned claims, the beneficiary assigns (i.e., transfers) his right to payment from Medicare to the physician. In return, the physician agrees to accept Medicare's "approved" or "reasonable" charge determination as payment in full for covered services. The physician bills the program directly and is paid an amount equal to 80% of Medicare's reasonable or approved charge (less any deductible, where applicable). The patient is liable for the 20% 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 approved charge and the physician's actual charge. In calendar year 1983, approximately 56% of claims were paid on an assignment basis. In 1984, the figure had risen to 59%. By 1985, the figure was 69%. This increase was primarily attributable to two factors -- the

beginning of the participating physicians program on October 1 and the new requirement that claims for independent laboratory services be assigned.

In the case of non-assigned claims, payment is made by Medicare directly to the beneficiary on the basis of any 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 approved charge.

A physician (except one who becomes 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, he is essentially 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.

#### D. Participating and Nonparticipating Physicians

A physician may become 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 specified period, generally 12 months. The first such period began Oct. 1, 1984. The next period began Oct. 1, 1985. A special 8-month period began May 1, 1986. Future 12-month periods will begin on Jan. 1 of each year beginning in 1987. The law requires physicians to sign up prior to the start of the participation period. After that time, 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. A physician who has signed up for one participation period is deemed to have signed up for future periods unless he terminates his agreement.

A nonparticipating physician is a physician who has not signed a voluntary participation agreement. A nonparticipating physician may accept assignment on a case-by-case basis.

The law includes a number of incentives to encourage physicians to become participating physicians. During the freeze period the primary incentive for physicians to participate was the ability to increase their billed charges. While increases in billed charges did not raise Medicare payments during the freeze period, these charges will be reflected in the calculation of future customary charge screen updates. The freeze was lifted for participating physicians on May 1, 1986; these physicians received an increase of 4.15% in their maximum allowable prevailing charges. Nonparticipating physicians will be subject to the freeze through Dec. 31, 1986. During the entire freeze period, nonparticipating physicians could not raise their actual charges above the levels charged during April-June 1984. Thus, there are two

prevailing charge levels applicable for physicians in a locality -- one for participating physicians and a lower one for nonparticipating physicians. All physicians will receive an increase of 3.2% in their maximum allowable prevailing charges, effective Jan. 1, 1987. In future years, the percent increase in the MEI would be applied to the previous prevailing charge for participating and nonparticipating physicians, respectively. There will be a permanent differential in the prevailing charges applicable for nonparticipating versus participating physicians.

The freeze is lifted for nonparticipating physicians effective Jan. 1, 1987. However, these physicians will be subject to a limit on their actual charges. (This is referred to as the maximum allowable actual charge or MAAC). Nonparticipating physicians, whose actual charge for a service in the preceding year equals or exceeds 115% of the current year's prevailing charge, could increase their actual charges by 1%. Nonparticipating physicians whose actual charge for the preceding year is below 115% of the current year's prevailing charge would be subject to a limit; they could increase their actual charges over a 4-year period so that in the fourth year the actual charge equals 115% of the prevailing charge. The MAAC for a nonparticipating physician whose actual charge for a service in the previous year is less than 115% of the current year prevailing charge is the dollar amount which is the greater of: (i) the amount 1% above the physician's previous year's actual charge; or (ii) an amount based on a comparison between the physician's MAAC for the previous year and 115% of the current prevailing charge. Under clause (ii), the MAAC for the current year equals the previous year MAAC increased by a fraction of the difference between 115% of the current year prevailing and the previous year MAAC. The applicable fractions are one-quarter, one-third, one-half and one for 1987, 1988, 1989, and 1990, respectively. For example, if a physician's 1986 MAAC for a service is \$100, and 115% of the 1987 prevailing charge amount is \$124, the 1987 MAAC for that physician for that service is \$106 [ $\$100 + 0.25(\$124 - \$100)$ ].

In addition to the payment provisions, the law includes additional incentives 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. Further, beginning on Oct. 1, 1986, all "Explanation of Medicare Benefits" (EOMB) notices sent to Medicare beneficiaries on unassigned claims must include a reminder of the participating physician and supplier program.

The law requires the Secretary to monitor charges of nonparticipating physicians to determine compliance with the fee freeze and the MAAC limits

Nonparticipating physicians who do not comply with the freeze or MAAC limits could be subject to civil monetary penalties or assessments, exclusion for up to 5 years from the Medicare program, or both. Civil monetary penalties may be imposed in amounts up to \$2,000 for each violation. The Secretary is given authority to make restitution to the beneficiary out of the amounts collected for any excess payments by the beneficiary. The restitution amount may not exceed either the excess amount the beneficiary was charged or the amount collected from the physician. The Secretary may not impose the exclusion penalty in the case of a doctor who is the sole physician serving a community or a physician providing essential specialized services which would otherwise be unavailable. Further, the Secretary, in determining whether to bar a physician from the program, is required to take into account the access of beneficiaries to physician services.

HCFA reports that for the participation period beginning Oct. 1, 1985, 27.9% of physicians billing Medicare were participating, 32.2% of limited license practitioners (i.e., chiropractors, dentists, podiatrists) were participating, and 23% of Medicare suppliers were participating. For the participation period beginning May 1, 1986, 28.3% of physicians (including limited licensed practitioners) are participating and 19.0% of suppliers are participating, for an overall participation rate of 27.1%.

#### E. "Inherent Reasonableness" Guidelines

The law has permitted the Secretary certain flexibility in determining reasonable charges. Regulations issued prior to COBRA allowed the use of "other factors that may be found necessary and appropriate with respect to a particular item or service...in judging whether the charge is inherently reasonable." COBRA required the Secretary to promulgate regulations which specify explicitly the criteria of "inherent reasonableness." Implementing regulations were issued Aug. 16, 1986. P.L. 99-509 further clarified congressional intent with respect to this authority.

By law, the Secretary is authorized to establish a payment limit for a physician's service based on considerations other than actual, customary, or prevailing for the service. A departure from the standard is appropriate under a number of specified circumstances including the following:

- Prevailing charges in a locality are significantly in excess of or below prevailing charges in other comparable localities, taking into account the relative costs of furnishing services.
- Medicare and Medicaid are the sole or the primary sources for payment.
- The marketplace is not truly competitive.
- There have been increases in charges for a service that cannot be explained by inflation or technology.
- The charges do not reflect changing technology, increased facility with that technology, or changes in acquisition or production costs.
- The prevailing charges for a service are substantially higher or lower than than payments by other purchasers in the same locality.

The Secretary is authorized to make an adjustment in payment if it is justified on the basis of an appropriate comparison of resource costs or charges. An adjustment may be based on one of the following types of comparisons: charges and resource costs for related procedures, charges and resource costs for a procedure over a period of time, charges for a procedure in different geographic areas, and Medicare charges and allowed payments for a procedure compared to those of other payors.

An adjustment in prevailing charges may be made only if the Secretary determines that a prevailing charge allowed in a locality is out of line with prevailing charges allowed in other localities after accounting for



differences in practice costs.

In determining whether to adjust payment rates, the Secretary would be required to consider the potential impacts on quality, access, and beneficiary liability including the likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians.

The law specifies procedures the Secretary is required to follow in the case of a proposed modification in payments based on inherent reasonableness criteria. If an adjustment is made which results in a reduction in allowed payments, a special limit on actual charges for nonparticipating physicians would apply. For the first year the reduction is in effect, the maximum allowable actual charge for the service equals 125% of the inherently reasonable charge level plus one-half of the difference between the physician's actual charge in the preceding period and 125% of the inherently reasonable charge. In the second year, the maximum allowable charge for the service equals 125% of the inherently reasonable charge level.

#### F. Cataract Surgery

Cataract surgery involves the removal (by various means) of the natural lens of the eye and replacement of the lens by a prosthetic (artificial) lens. Prosthetic lenses include externally worn contact lenses, eyeglasses, and most commonly, artificial lenses that are surgically implanted in the patient's eye. Cataract extractions with an intraocular lens implant (IOL) currently account for 90% of all cataract surgeries.

On Aug. 15, 1986, the Department issued two proposed Notices relating to the establishment of special reasonable charge limits (see discussion of inherent reasonableness under A above). The first Notice proposed establishment of a limit for cataract extractions with (IOL) implants. Under this Notice, a limit on cataract surgery with IOLs would be phased in over 3 years, so that for services furnished in calendar year 1989 and thereafter the limit on prevailing charges would be set at 110% of prevailing charges for cataract surgery without an IOL. (A similar limit, with no phase-in period, was contained in the Energy and Commerce Committee version of the 1986 reconciliation bill, H.R. 5300). In proposing the limitation, the Notice cited data from a variety of sources which indicated that cataract procedures are overpriced. In addition, the Notice noted that HCFA had been advised by ophthalmologists that a cataract procedure with an IOL takes only about five additional minutes. However, the prevailing charge level is approximately 50% higher than that for cataract surgery without an IOL. The Department's second Notice proposed limits for anesthesia services related to cataract surgery.

The Congress reviewed the proposed payment limitations for cataract surgery and provided for a different calculation than had been proposed by the Department. Under the provisions of P.L.99-509, the maximum allowable prevailing charges, otherwise recognized for participating and nonparticipating physicians performing a cataract surgical procedure, are to be reduced by 10% with respect to procedures performed in 1987. They are to be further reduced by 2% with respect to procedures performed in 1988. In no case may the reduction for a surgical procedure result in a prevailing charge that is less than 75% of the weighted national average of such prevailing charges for such procedure for all localities in the U.S. in 1986.

P.L. 99-509 ratified the final regulations issued by the Department Oct. 7, 1986, with respect to anesthesia services related to cataract surgery. This regulation (which is unchanged from the proposed Notice issued Aug. 15, 1986) sets limits on reasonable charge payments for anesthesia services furnished by physicians during cataract surgery and iridectomies (i.e., excision of a portion of the iris). The regulation is effective Jan. 1, 1987. Under current reimbursement rules, carriers calculate the reasonable charge for anesthesia services based on the following:

- Base units assigned to the specific procedure that represent the value of all anesthesia services except the value of the actual time spent administering the anesthesia. Generally carriers are assigning a value of eight base units to the anesthesia services associated with cataract surgery procedures.
- Time units that represent the elapsed period of time from when the anesthesiologist prepares the patient for induction and ending when the anesthesiologist is no longer in personal attendance to the patient. One time unit is allowed for each 15 minute interval.
- The carrier may use modifier units that take into account special factors such as age or physical condition of the patient.

A physician may also be reimbursed on a reasonable charge basis for the personal medical direction that he furnishes to a qualified anesthetist; to receive such payments, the physician may not direct more than four concurrent anesthesia procedures at a time.

The regulation allows no more than four base units as well as appropriate time and modifier units for anesthesia services connected with cataract surgery. The regulation notes that almost all cataract surgery is now being performed on an ambulatory basis. General anesthesia is not ordinarily used. The regulation states that most surgery is done under local anesthesia administered by the ophthalmologist while the anesthesiologist is responsible for monitoring the patient's condition. A similar limit of four base units would be allowed for an iridectomy, which is described as no more complex than cataract surgery. The selection of four base units as a limit represents one unit above the three units which is the least number of units assigned to most surgical procedures performed on an ambulatory basis. The estimated savings related to the cataract surgery portion of this regulation is estimated to be \$45 million in FY87 rising to \$105 million in FY91. The savings related to iridectomies would be under \$1 million in FY87; higher annual savings are not projected for future years. The regulation also allows no more than three base units for each procedure in those cases in which the anesthesiologist is performing more than four concurrent procedures. HCFA was unable to estimate the savings attributable to this proposal, but indicated it would probably not be substantial.

## II. RECENT LEGISLATION

Recent legislation, beginning with the enactment of DEFRA in 1984, made

significant modifications in the physician payment provisions of Medicare.

A. P.L. 98-369, the Deficit Reduction Act of 1984 (DEFRA)

On July 18, 1984, the President signed into law the Deficit Reduction Act of 1984 (DEFRA). This legislation froze physicians' fees under Medicare for the 15-month period, July 1, 1984, through Sept. 30, 1985. Therefore, the annual updating of customary and prevailing charge screens, otherwise slated for July 1, 1984, did not occur. Subsequent fee screen updates were slated to occur on October 1 of future years beginning in 1985. No catch-up would be permitted to account for any economic index increase to the prevailing charge screen that would otherwise have occurred during the freeze period.

The law also established the concept of participating physicians and specified that the first participation period began Oct. 1, 1984. The law provided that participating physicians were subject to the 15-month freeze. They were, however, permitted to increase their billed charges during the freeze period. While increases in billed charges would not raise Medicare payments during the freeze period, these charges would be reflected in the calculation of future customary fee screen updates. The law included additional incentives for physicians who agreed to become participating physicians. These included the publication of directories identifying participating physicians and the maintenance by carriers of toll free lines to provide beneficiaries with names of participating physicians.

The law specified that nonparticipating physicians could not increase their billed charges during the 15-month freeze period over the amounts charged for the same services during the Apr. 1, 1984, through June 30, 1984, 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% 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 required the Secretary to monitor charges of nonparticipating physicians and specified penalties for those who failed to comply with the freeze.

The legislation authorized payments from the Part B trust fund to carriers of no less than \$8 million in FY84 and \$15 million in FY85 to enable them to meet the increased costs of activities required under the new law.

B. Temporary Extensions

During 1985 and early 1986, the Congress considered several alternative proposals to modify and extend the physician payment provisions of DEFRA. Both the House-passed and Senate-passed reconciliation bills contained related provisions, though the bill was not enacted until Apr. 7, 1986.

During consideration of reconciliation legislation there was concern that the freeze on nonparticipating physicians would expire and then be reinstituted shortly thereafter. To avoid this situation, Congress approved the Emergency Extension Act of 1985 (P.L. 99-107), which extended the fee freeze provisions through Nov. 14, 1985. Subsequently it approved four amendments to that Act, further extending the freeze provisions, as follows:

- o P.L. 99-155 -- extended through Dec. 14, 1985.
- o P.L. 99-181 -- extended through Dec. 18, 1985.
- o P.L. 99-189 -- extended through Dec. 19, 1985.
- o P.L. 99-201 -- extended through Mar. 14, 1986.

C. P.L. 99-272, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

On Apr. 7, 1986, the President signed into law P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985. This bill represented the culmination of legislative activity on the President's FY86 budget proposals for Medicare and certain other programs. As noted, this legislation makes several significant modifications to the Medicare physician payment provisions.

Under COBRA, the existing payment provisions were extended through April 1986. In April 1986, physicians were given an opportunity to change their participation status for the 8-month period beginning May 1, 1986. Future update and participation cycles will begin on Jan. 1 of each year, beginning in 1987.

Physicians covered under participation agreements on May 1, 1986, received updates in their customary and prevailing charges. Physicians who participated in FY85 but are not participating for the period beginning May 1, 1986, had their customary charges updated. For physicians participating during neither period, the existing freeze on customary and prevailing charges was extended through Dec. 31, 1986. The freeze on actual charges was extended for all nonparticipating physicians for the same period.

The customary and prevailing charge screen updates applied on May 1, 1986, are those which would have occurred on Oct. 1, 1985, except for postponements provided for under temporary extension legislation. To compensate participating physicians for the delay, the Medicare Economic Index was increased by one percentage point increase. This increase was not built permanently into the prevailing charge levels. (See modification contained in P.L. 99-509, discussed below.)

COBRA provided that, beginning Jan. 1, 1987, nonparticipating physicians would be subject to the prevailing charge limits applied to participating physicians during the preceding participation period. (See modification contained in P.L. 99-509, discussed below.) The law required publication of directories (rather than a single directory, as previously required) identifying participating physicians. In addition, the "Explanation of Medicare Benefits" (EOMB) notices sent to beneficiaries is required, for nonassigned claims, to include a reminder of the participating physician and supplier program.

COBRA also provided for the establishment of an independent Physician Payment Review Commission. The mission and ongoing duties are to make recommendations regarding Medicare physician payments. The Commission members were appointed on June 11, 1986.

The law also required the Secretary, with the advice of the Commission, to develop a relative value scale (RVS) for physician payments (see Part IV for a discussion of RVSSs). The Secretary is required to complete the development of the RVS and report to Congress on its development by July 1, 1987. The report is to include recommendations concerning its potential application to

Medicare on or after Jan. 1, 1988. (See P.L. 99-509 modification.)

COBRA also includes the following additional provisions relating to payment for physician services:

- The law has permitted the Secretary certain flexibility in determining reasonable charges. Regulations allowed the use of "other factors that may be found necessary and appropriate with respect to a specific item or service... in judging whether the charge is inherently reasonable." COBRA required the Secretary to promulgate regulations which specify explicitly the criteria of "inherent reasonableness."
- COBRA made technical corrections with respect to the calculation of customary charges for certain former hospital-compensated physicians.
- COBRA required the Secretary to provide for separate payment amount determinations for cataract eyeglasses and cataract contact lenses and for the professional services related to them. The Secretary is to apply inherent reasonableness guidelines in determining the reasonableness of charges for such eyeglasses and lenses.
- COBRA denied Medicare payment for assistants-at-surgery in a cataract operation unless prior approval is obtained from the peer review organization (PRO) or Medicare carrier. Such assistants cannot bill Medicare or the beneficiary for services which do not receive prior approval; nor can the primary physician bill for such services. COBRA further required the Secretary to report to Congress by Jan. 1, 1987, recommendations and guidelines regarding other surgical procedures for which an assistant-at-surgery is not generally medically necessary.

D. Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509)

On Oct. 17, 1986, the Conference Committee issued its report on H.R. 5300. On the same date, the measure passed the House and the Senate. The bill was signed into law by the President on Oct. 21, 1986, as the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509). Title IX of this law contains Medicare provisions, including several amendments to the physician payment requirements. The following is a summary of the major physician payment provisions included in the law.

1. Payment Provisions

Under current law, a fee freeze went into effect July 1984; the freeze was lifted for participating physicians May 1, 1986. It will be lifted for nonparticipating physicians Jan. 1, 1987. Annual increases (except during the freeze period), in prevailing charges are limited by the Medicare Economic Index (MEI), which reflects general inflation and changes in physicians office practice costs. The law includes a number of amendments to the physician payment provisions, as follows:

- Beginning in 1987, all participating and all nonparticipating physicians will receive an increase in their prevailing charge levels, above those in effect for the previous period equal to 3.2%. In 1988 and future years, prevailing charges would be increased by the percentage increase in the MEI.
- The one percentage point increase over the MEI, which was allowed for participating physicians for the period beginning May 1, 1986, is built into the base for future calculations.
- The Secretary could not retrospectively revise the calculation of the MEI (as had been recommended by the Administration). The Secretary is required to conduct a study of the MEI to ensure that the index reflects economic changes in an appropriate and equitable manner. The Secretary is precluded from changing the methodology used to determine the MEI until completion of the study.
- Nonparticipating physicians will be subject to a limit on their actual charges when the freeze is lifted Jan. 1, 1987. (This is referred to as the maximum allowable actual charge or MAAC). Nonparticipating physicians, whose actual charge for a service in the preceding year equals or exceeds 115% of the current year's prevailing charge, could increase their actual charges by 1%. Nonparticipating physicians whose actual charge for the preceding year is below 115% of the current year's prevailing charge would be subject to a limit; they could increase their actual charges over a 4-year period so that in the fourth year the actual charge equals 115% of the prevailing charge. Carriers are required to provide each nonparticipating physician with a list of MAACs for the procedures most commonly provided by the physician at the beginning of each year.
- By July 1, 1989, the Secretary is required, after appropriate notice and consultation, to consolidate the procedure codes contained in the HCFA Common Procedure Coding System (HCPCS) for payment purposes.

## 2. Incentives for Participation

The law makes the following additional changes to encourage physicians to become participating physicians:

- A letter is to be sent annually to each beneficiary, in the beneficiary's social security check, reminding beneficiaries of the participating physician program and offering a copy of the participating

physician directory. The letter is to indicate that a free copy would be sent on request.

- Carriers are required to implement programs to recruit and retain physicians as participating physicians. Carriers are also required to implement programs to familiarize beneficiaries with the participating physician program and assist them in locating participating physicians. An incentive pool, equal to 1% of total payments to carriers for claims processing will be available to reward carriers for their success in increasing the percentage of participating physicians in the carrier's service area.
- A physician is required to refund on a timely basis any beneficiary payments collected in connection with a non-assigned claim when the service is determined by a peer review organization or carrier to be medically unnecessary. A refund would not be required if: (1) the physician did not know, and could not reasonably be expected to have known, that the service would be found unnecessary; or (2) the beneficiary was informed in advance that Medicare payment would not be made.
- Where the actual charge for a nonassigned elective surgical procedure exceeds \$500, the physician is required to disclose to the individual in writing, the estimated charge, the estimated approved charge, the excess of the physician's actual charge over the approved charge, and the applicable coinsurance amount. The written estimate may not be used as evidence in a civil suit.
- Hospitals are required to make available the appropriate participating physician directory, and where referral is made to a nonparticipating physician, inform the beneficiary of the fact. Wherever practicable, the hospital must identify a participating physician from whom the patient can receive the necessary services.

### 3. Inherent Reasonableness; Payments for Cataract Surgery.

COBRA required the Secretary to promulgate regulations which specify explicitly the criteria of "inherent reasonableness" for determining Medicare payments to physicians; the Administration proposed to apply inherent reasonableness guidelines to cataract procedures in order to reduce Medicare payments for these services. P.L. 99-509 authorizes the Secretary under the inherent reasonableness authority, to establish a payment level for physician services based on criteria other than the actual, customary, and prevailing charge for the service. The law specifies criteria and procedures for adjusting payment levels. The Secretary is required to review, by Oct. 1, 1987, the inherent reasonableness of payments for 10 of the most costly procedures paid for under Part B.

The law reduces by 10% the prevailing charges for cataract surgical procedures performed in 1987; in 1988, the prevailing charge is reduced by 2%. In no case could the reduced prevailing charge level be lower than 75% of the national average prevailing charge.

#### 4. Recommendations for Relative Value Scale

COBRA required the Secretary, with the advice of the newly established Physician Payment Commission, to develop a relative value scale (RVS) for physician payments. The law defers the date the Secretary is required to report on the RVS to July 1, 1989. The potential application date of the RVS is deferred until after Dec. 31, 1989. The law further requires the Secretary, in making recommendations for application of an RVS to: (1) develop and assess an appropriate index to reflect justifiable geographic variations in practice costs without exacerbating the geographic maldistribution of physicians; and (2) assess the advisability and feasibility of developing an appropriate adjustment to assist in attracting and retaining physicians in medically underserved areas. The Secretary is to develop an interim geographic index by July 1, 1987, and collect data for refining the index by Dec. 31, 1989.

#### 5. Radiology, Anesthesiology and Pathology Services Study

The Secretary is required to study and report to Congress by July 31, 1987, concerning the design and implementation of a prospective payment system for payment under Part B for radiology, anesthesiology, and pathology (RAP) services furnished to hospital inpatients. The report is to include data, from a representative sample, showing for discharges classified within each diagnosis-related group (DRG), the distribution of total reasonable charges and costs for each inpatient discharge.

### III. Implementation of OBRA

In December 1986, the Department issued instructions to Medicare carriers pertaining to implementation of the participating physician payment and the maximum allowable actual charges (MAAC) provisions of OBRA. On Dec. 24, 1986, the American Medical Association filed a lawsuit in the U.S. District Court for the Northern District of Texas concerning implementation of the OBRA provisions. It requested a preliminary injunction to delay the deadline beyond Jan. 1, 1987 for signing up as a participating physician. A temporary restraining order was granted on Dec. 31, 1987. On Jan. 20, 1987, the court dissolved the temporary restraining order. Subsequently, the Department notified carriers that physicians had until Jan. 30, 1987, to decide whether to participate in 1987. Payment would be made according to the requirements of law (i.e., nonparticipating physicians are subject to a prevailing charge level equal to 96% of that for participating physicians, effective Jan. 1, 1987).

### IV. President's FY88 Budget



On Jan. 5, 1987, the President transmitted the proposed FY88 Budget which included several proposed modifications to physician payment provisions. Total savings attributable to these provisions were estimated at \$200 million in FY88. The following outlines these provisions.

A. Prospective Payment of Radiology, Anesthesiology, and Pathology Services Provided by Physicians to Hospital Inpatients (so-called RAP proposal)

Under current law, payments are made to physicians on the basis of reasonable charges per unit of service.

The budget proposal would modify the mechanism used to pay for radiology, anesthesiology, and pathology (RAP) services provided to hospital inpatients. Medicare would pay an average rate per discharge for all RAP services associated with the diagnostic category.

The fee-for-service payment methodology has been characterized as inherently inflationary. As a result several alternative payment methodologies are being studied. One alternative which has been examined is that of making pre-determined payments by diagnosis-related groups (DRGs) for physician services provided to hospital inpatients. However, a number of concerns have been raised with respect to implementation of this approach (see discussion of DRG approach, Part VII, B below). It has been suggested that it may be appropriate to institute payment reforms for a more narrowly defined classification of services. RAPs have been selected for several reasons including their close connection with hospitals and the fact that competitive forces do not operate with respect to utilization of RAP services since patients do not generally select their RAP provider.

The specifics of the Administration proposal are not currently available. A number of questions could be raised with regard to its implementation including how will the payment amount be calculated; to whom will the payment be made; how will beneficiary cost-sharing charges be calculated; and will there be limits on charges that physicians will be able to bill patients in excess of the recognized payment amount. Over half of the members of both House of Congress are cosponsors of resolutions (H.Con.Res. 30, S.Con.Res. 15, and S.Con.Res. 56) opposing this approach.

B. Additional Physician Payment Reforms

The Budget included the following additional reform Proposals:

- Reduce prevailing charges for cataract surgery by an additional 13% in FY88 (OBRA provided for a 10% reduction in FY87 and 2% in FY88);
- Establish customary charges for new physicians at approximately 80% of the prevailing charge; (they are currently set at 75% of customary charges);
- Provide reductions for physicians charges that are overpriced compared with other procedures; charges

that vary excessively from one location to another;  
and global surgical fees that do not reflect recent  
reductions in hospital lengths of stay; and

- Place limits on prevailing charges for certain medical or surgical services (excluding visits or consultations) where there is a large disparity between the charges of specialist and non-specialist.

## V. CURRENT SYSTEM ISSUES

Total Medicare outlays rose at an average annual rate of 18.2% over the FY79-FY83 period. Part A outlays increased at an average rate of 17.3% while Part B outlays increased at an average annual rate of 20.6% over the same period. For a number of years, Part A outlays received the most attention both because of the relative size of the Part A program (\$49.7 billion in FY86 compared to \$26.2 billion for Part B) and because of the potential exhaustion of the Part A Hospital Insurance trust fund (the projected exhaustion date of the Part A trust fund is currently 1996). Part B is "currently financed" through enrollee premiums and Federal general revenues. The Part B trust fund will not technically go broke because premium amounts and general revenue contributions are automatically increased each year. However, the rapid cost increases and the resulting impact on the Federal budget have caused increasing concern. Since approximately three-quarters of Part B outlays are for physician 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.

Despite the changes made by DEFRA and COBRA, Medicare's basic fee-for-service payment system has remained relatively unchanged since the program's inception. Payments are made, subject to certain limitations, for each service rendered. It has been suggested that both the individual prices and the unit of payment (i.e., the individual service) are inflationary and permit certain distortions. The system has also been criticized for failing to provide adequate protection for the elderly against rising physicians' fees.

### A. Prices for Individual Services

As noted in Part I, Medicare pays for individual services on the basis of "approved" or "reasonable" charges. Reasonable charges cannot exceed the physician's customary charge or the prevailing charge for the service in the community. Annual increases in recognized prevailing charge levels are subject to the economic index limitation (which is expressed as a percentage). Physicians' fees generally have increased at a faster rate than the economic index. Between 1973 and 1984, the economic index increased by 106% while physician fees, as measured by the physician services component of the Consumer Price Index (CPI), increased 157%. Thus each year an increasing percentage of physicians' customary charges are likely to exceed the index-adjusted prevailing charge. In these cases, the index-adjusted prevailing charge levels are determining the approved payment amounts. It is estimated that a significant number, though less than one-half of physicians' charges are subject to the economic index limitation.

The index-adjusted prevailing charge levels are serving, in many

localities, as de facto fee schedules. 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.)

The de facto fee schedules, which vary considerably throughout the country, reflect and lock into place historical imbalances in charging patterns. Many feel that the payment imbalances in the current system 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. The following are some of the major problems which have been cited:

-- General Practitioner/Specialist Differential.

Considerable variation exists in fees recognized by the program for certain medical services performed by physicians in general practice versus fees 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 may provide a different type or higher quality of service. However, there is concern that these fee differentials may not be warranted and may have encouraged increased specialization. Further, these 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% higher than that for generalists for a "brief follow-up hospital visit" and 24% higher for a "brief follow-up office visit."

Neither Medicare nor the medical community generally has established a single uniform definition for the term specialist. A recent 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 recognition was warranted for particular procedures, and in turn, the carriers had conducted little or no analyses. The report cited wide differences in the way carriers recognize physician specialties in establishing prevailing rates. Some carriers did not recognize any specialties and had only one prevailing rate for a particular procedure; others developed prevailing charges for each specialty individually; while still others combined numerous specialties into several prevailing rate groups. The report noted that the

use of more than one prevailing rate could lead to significant variations among specialties. For example, for the fee screen year beginning July 1, 1981, the prevailing rate 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 reviewed the practice of "self-designation" -- i.e., a physician may classify himself as specialist without necessarily 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 specialties were not board certified in that specialty and about one-fourth of the physicians who designated subspecialties in internal medicine were not even board-certified in internal medicine.

- Geographic Variations. Significant variations exist by geographic area in physicians' fees recognized by Medicare for the same service. 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%. Such differentials are not totally justified by cost-of-living differences. They also reflect historical charge patterns.
- Failure of Prices to Fall as Pricing Patterns Change. Physicians' charges for new procedures are generally set at a high level reflecting the fact that new procedures may initially 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 costs. An example of such charging patterns which is frequently cited 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.
- 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% higher in a hospital than in an office. Similarly for the same service performed by a specialist, the average prevailing

charge was 12% 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. Costs to a physician are lower for services performed in a hospital outpatient department compared to an 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%.

- Medical Visit/Surgical ("Cognitive/Procedural") Differentials. Hospital-based procedures, particularly surgical procedures and those requiring substantial fixed equipment (such as certain diagnostic tests) are generally priced higher than office-based services. This raises the concern that the existing payment mechanism may encourage the use of services which not only command high physicians' fees but also consume large amounts of support and technical resources. The parallel concern is that the system may discourage physicians from spending time with patients to counsel or examine them. The resulting payment imbalances are sometimes referred to as the "cognitive/procedural differential" though this term may be misleading.

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 (HCFA Review, Fall 1979) focused on the professional time expended and the complexity of the service. After standardizing for complexity between selected procedures, the study showed that physicians were paid as much as 4-5 times more per hour for hospital-based surgery than for office visits. A follow-up study using 1983 data (as outlined in testimony before the Senate Finance Committee Dec. 6, 1985), showed that values of surgical procedures relative to office visits are, at a minimum, 2 or 3 times higher when calculated on the basis of charges than when calculated from resource inputs.

#### B. Unit of Payment

Another concern with the current reimbursement methodology is Medicare's 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, the majority of all physician payments are made for small units of service. It has been argued that in this environment physicians are not discouraged from providing additional services (such as laboratory tests), ordering additional consultations, or performing 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.

Further compounding the inflationary effect is the phenomenon known as "unbundling," i.e., billing separately for services previously consolidated into a larger unit of payment. 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 one of the more significant contributors to inflation in expenditures for physician services.

It has also been suggested that existing coding policies may be somewhat inflationary. Procedure codes for some high volume services such as office visits are not precisely defined. It may therefore 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 also facilitate code creep.

The impact of these increases is reflected in data on the components of increases in recognized charges per enrollee for physician services. The 1986 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, 1984, about one-third of the total percentage increase in physician expenditures per enrollee was due to the "net residual factors" (3.2% out of a total of 11.6%). For the year ending Sept. 30, 1985, when the freeze was in effect, these residual factors were expected to account for 84% of the total increase per enrollee (5.2% out of a total 6.2%).

Volume increases, unbundling, and code creep are thus important factors in determining the level of overall expenditures for physician 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 (ESP) program during the early 1970s is frequently cited as an illustration of this phenomenon. Analysis by the Urban Institute of the ESP program 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.

Physicians have had considerable discretion in determining price and volume of services. It is estimated that physicians' decisions (such as ordering hospitalization, drugs or laboratory tests) directly influence over 70% of all health care expenditures.

### C. Patient Liability

Physicians' decisions about pricing and billing also have a direct

economic impact on patients. All patients are liable for the 20% coinsurance charges though Medicaid or private Medi-Gap insurance may pick up 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 picked up by private insurance policies.

The difference between the physician's billed charge and Medicare's approved or reasonable charge is referred to as the reasonable charge reduction. Reasonable charge reductions were made on 84.5% of unassigned claims in FY85. The amount of the reduction was 25.9% of billed charges or \$33.37 per approved claim. Beneficiaries were liable for these reduction amounts. (Comparable figures 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% of claims were paid on an assignment basis in 1984. The AMA Center for Health Policy Research reported that for physicians who treated some Medicare patients in 1984, 83.9% accepted assignment for at least some patients, an increase over the 75.6% recorded in 1982. In 1984, 32.1% of physicians always accepted assignment, and 16.1% never accepted assignment. Physician assignment behavior varied by region and by specialty.

Physicians have been able to accept or refuse assignment on a claim-by-claim basis. However, under the provisions of DEFRA, physicians may become "participating physicians." As of this time, data is not available on how the implementation of the participating physician provision has affected beneficiary out-of-pocket payments.

## VI. REFORM OPTIONS

For several years, both the Congress and the Administration have been exploring alternative approaches to dealing with escalating expenditures for physician services under Medicare. Proposals for a 1-year freeze on customary and prevailing charges were rejected for several years primarily because of the concern that more physicians would refuse assignment, thereby passing along to the beneficiary the costs not met by the program.

In 1983, the House Ways and Means Committee reported the Tax Reform Act. The reported bill included a committee amendment which would have placed a 1-year freeze on physicians' fees for services provided to hospital inpatients and would have required physicians to accept assignment for such services. The provision was to be subject to a separate vote when the bill reached the House floor. In the intervening period, the American Medical Association announced a voluntary 1-year freeze on physicians' fees and launched a strong campaign against mandatory assignment. The mandatory assignment provision was defeated by a voice vote on Apr. 12, 1984.

The Deficit Reduction Act of 1984 included a 15-month freeze on physicians' fees and established the concept of "participating" physicians. The provision 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 fee freeze was extended through Apr. 30, 1986, for participating physicians and Dec. 30, 1986, for nonparticipating physicians. However, the freeze

provisions were viewed as an interim approach until more permanent changes can be incorporated into the system.

Serious consideration of major reforms has been hampered by a number of factors. These include major gaps in the data on what the program is currently paying for, opposition by a number of physicians to a major alteration in the fee-for-service/ voluntary assignment approach, and the uncertainty concerning the actual impact of major reforms on both the program and beneficiaries.

However, in addition to rising fiscal concerns, changes both 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 in response to the developing oversupply (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, Medicare is implementing a major new prospective payment system (PPS) for hospitals which is replacing the earlier "reasonable cost" reimbursement system. Under PPS, hospitals are paid a predetermined rate for each inpatient stay based on the patient's clinical and demographic characteristics and the nature of the treatment received. The classification system used to group hospital patients is known as Diagnosis Related Groups (DRGs). The system is being phased in over a 4-year period beginning on Oct. 1, 1983. [For a discussion of prospective payment, see CRS Issue Brief 83171, Prospective Payments for Medicare Inpatient Hospital Services.] 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 alternative 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 fee schedules, paying for physician services on the basis of DRGs, or paying for services on a capitation, i.e., per person, basis. Reforms in the existing system could be restricted to services provided in an inpatient hospital setting (approximately 62% of physicians' expenditures) or could be applied to all physicians' services. Payment reforms might be taken either 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 amount paid 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 than 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 fee schedule. This would have the advantage of removing the wide fluctuations in payments for similar services though certain areawide adjustments for cost-of-living differentials might be permitted. Physicians would know in advance what Medicare's payment would be. At the same time, Medicare would have some control over the amount paid for individual services. However, this approach would have less impact on overall expenditures unless controls on intensity and volume were also incorporated in the new system.

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

A RVS is a method of valuing individual services in relationship to each other. Each service is assigned an abstract index number or weight. For example, an initial office visit could be assigned a value and other services assigned higher or lower numbers to indicate their "value" relative to an initial office visit. A RVS is not a fee schedule. It is translated into a fee schedule by use of a predetermined "conversion factor" or multiplier. For example, if the multiplier was 4, an initial office visit with a relative value of 4.9 would be priced at \$19.60.

RVSs are frequently discussed in terms of a system which could reflect individual time, skill, and overhead costs that each service requires. Ultimately the goal would be to establish RVSs which are economically neutral in terms of what services are performed, the setting where services are rendered, and the region in which the physician practices.

However, to date, RVSs have generally been developed on the basis of charges. 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 fee data derived from files of third party payers in the State. Attempts were not made to adjust the charge data based on potential measures of relative "value." Several other professional societies, some Blue Shield plans, and some commercial insurance companies 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.

Several studies are underway, which attempt to determine the relative values of services based on physician time, complexity of service and similar factors. A number of segments of organized medicine have expressed strong interest in developing or assisting in the development of an RVS.

A study by the Urban Institute ("Final Report on Alternative Methods of Developing a Relative Value Scale of Physicians' Services, October 1984) attempted to explore alternative means of constructing RVSSs. The first year's study concluded that cost-related information on such factors as time per procedure, complexity, severity, and resource costs are insufficient to allow timely development of a reliable cost-based RVS. The authors concluded that use of charge-based data was the preferable alternative. The report suggested that a "consensus development" process (i.e., group decisionmaking) could serve a useful role in the review, evaluation, and adjustment of an RVS based on charges. Using this approach, a panel would modify the index values which appeared out of line based on other measures of value such as production costs. The final report recommended a three-step process. The first step would be to develop a relative cost scale based on a scale modified from relative charges using limited cost information and experts' assessments of each service's profitability. The second step would be to convert 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. The final step involves converting the relative value scale into a fee schedule.

A key issue in the establishment of a fee schedule is the determination of the payment unit. If separately identifiable payments continued to be made for each individual service, the existing incentives for unbundling, code creep, and volume would remain. It may be possible to counter these incentives by defining common services more precisely and defining components of services as part of single more comprehensive units. However, there are some technical problems related to defining some larger packages of services 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 there would be some "winners" and some "losers" under the new system, i.e., 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 would therefore 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.

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.

Several recent developments have occurred with respect to development of an RVS. On Jan. 15, 1986, the Department of Health and Human Services entered into a 30-month cooperative agreement with Harvard University for development of an RVS. William Hsiao is the principal investigator and the American Medical Association is a subcontractor. The RVS is to be based on resource costs taking into account time, complexity, opportunity costs, and overhead. During the development of the RVS, it is also expected that procedures will be identified which are currently overpriced or underpriced.

As noted earlier, COBRA, as modified by P.L. 99-509, required the Secretary, with the advice of the newly established Physician Payment Review Commission, to develop a RVS and report to Congress on its development by July 1, 1989. The report is to include recommendations concerning its potential application to Medicare on or after Jan. 1, 1990.

#### B. Physician DRGs

As noted above, 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 physician 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 Feb. 20, 1987.

It is 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.

A physician DRG 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 episode. In certain 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. However, for many DRGs, particularly nonsurgical DRGs, it would be difficult to define what preadmission and/or post discharge time period should be considered part of the inpatient episode for reimbursement purposes.

There is concern that the existing DRG classification system which was designed to reflect hospital costs may not in all cases fully reflect differences in physician input costs. A recent study ("Creating DRG-Based Physician Reimbursement Schemes," by Janet Mitchell, Oct. 1984) showed that while there is relatively little variation in doctors' approved charges for cases within specific surgical DRG categories, there were wide variations in doctors' approved charges for cases within medical DRG categories. Making

payments on the basis of physician DRGs could thus involve large numbers of "winners" and "losers" for medical DRGs. Some of these individual effects could be partially offset depending on how the payments are made.

One of the key issues in designing a physician DRG payment system for inpatient services is determining to whom the payment should actually be made. Payments could be made to the attending 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 requiring more intensive care than the average for a particular DRG. Placing an individual physician at risk could potentially 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. Attending physicians 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. 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, while placing additional burdens on hospital staffs, has 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 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, this approach would place the institution in the position of arbitrating payment disputes among physicians and, in the case of combined payments, among physicians and other competing interests.

A physician DRG payment scheme 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. 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 the 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. 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 as effective in controlling overall expenditures. For example, certain complex cases might be 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 setting -- roughly 35-40% of total physician expenditures. At this point, it is generally agreed that the capability does not exist to extend the 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 number of persons have suggested that a DRG payment approach may not be appropriate for all physician services provided on an inpatient basis. However, a number have suggested this approach might be appropriate for payment for services provided by hospital-based physicians, generally radiologists, anesthesiologists, and pathologists (the so-called RAPs). P.L. 99-509 requires the Department to study this issue. The President's FY87 Budget includes a RAP proposal (see discussion, Part IV A, above); the specifics of this proposal are not currently available.

### C. Capitation

A third reform option is that of capitation. Medicare currently pays some providers (i.e., risk contracting HMOs and competitive medical plans) on this basis. It is expected that the number of beneficiaries who are covered under these arrangements will grow substantially over the next few years. The Administration favors extension of this approach to additional beneficiaries.

Under an alternative capitation approach known as geographic capitation, Medicare would contract with an entity, such as a carrier, which would serve as an at-risk insurer in a defined geographic area. Medicare would essentially purchase a specified package of services (physician services, all Part B services, or Part A and Part B services) for a specified per person price. The entity would be responsible for determining payment amounts and payment units. To assure beneficiary access to care at predictable levels of out-of-pocket costs, an entity could be required to obtain physician participation agreements from a certain percentage of physicians in the geographic area. Certain financial incentives might be employed (such as reduced cost-sharing) to encourage beneficiary use of participating physicians.

The Federal Government would be required to determine the per person payment amount. Medicare uses 95% of the Average Adjusted Per Capita Cost (AAPCC) calculation for paying at-risk health maintenance organizations (HMOs) and competitive medical plans (CMPs). The AAPCC is an estimate of the average per person cost of Medicare benefits in the area. A similar calculation could be made for an area-wide capitation system. However, many persons feel that the AAPCC calculation does not adequately reflect variations in the health status of enrolled population resulting from selective (i.e., voluntary) enrollment. A capitation amount would be relatively easy to calculate if the system were mandatory for all

beneficiaries. However, a mandatory approach is probably not feasible at this time. There is relatively little experience with the concept of geographic capitation systems. Several have suggested the possibility of a demonstration project in this area.

#### D. Assignment/Participation Issues

Regardless of the reform option chosen, a decision would need to be made about whether physicians would be required to accept Medicare's payment rate as the full payment (plus any required coinsurance) or if physicians would be permitted to charge additional amounts. The question is whether assignment should 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, many patients have difficulty understanding how Medicare determines payment. A number of beneficiaries have been faced with high and in many cases unanticipated out-of-pocket costs in connection with their doctors' bills. In FY85, beneficiaries effectively faced a coinsurance of 45.9% on unassigned claims; they were financially responsible for the 25.9% average reduction from billed charges in addition to the 20% statutory coinsurance amount. It may be difficult for beneficiaries to budget for the reduction amounts associated with unassigned claims. Frequently, these amounts are not covered under health insurance policies supplemental to Medicare ("Medi-Gap" policies). The Deficit Reduction Act of 1984 addressed some of these concerns by prohibiting nonparticipating physicians from raising their billed charges during the 15-month freeze period. These provisions were extended through Dec. 31, 1986. Beginning Jan. 1, 1987 when the freeze is removed, nonparticipating physicians will face a limit on the allowable increases in their charges.

Proponents of mandatory assignment also suggest that the existing problems will be exacerbated as Medicare places additional limits on approved charges. They suggest that physicians may be less likely to accept assignment and that any Medicare cost-savings will be transferred to beneficiaries in the form of increased out-of-pocket costs for unassigned claims. Thus any incentives for efficiency which are incorporated in a new payment system could be largely offset unless assignment were mandated. They further suggest that mandatory assignment would be particularly important under a physician DRG payment scheme. 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 specialties would therefore be jeopardized. Patients who have established a

long-standing relationship 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 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. They suggest that physicians are more willing to accept assignment in cases of financial hardship. They note that physicians 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.

The law includes several incentives for physicians to become participating physicians. A number of persons have suggested that in lieu of mandating assignment attention should be focused on creating additional incentives for physicians to participate. For example, Medicare could pay a higher percentage (i.e., above 80%) of the approved rates for participating physicians and a reduced percentage (i.e., below 80%) for nonparticipating physicians. Patients would then have strong incentives for selecting participating physicians.

## VII. CONGRESSIONALLY MANDATED STUDIES

A number of entities, both governmental and private, are currently 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, but which had not been submitted by Nov. 20, 1986.

- 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 physician services on the basis of DRGs. DEFRA specified that the due date was July 1, 1985.
- Study of Change in Volume and Mix of Services. DEFRA required the Secretary to monitor physician 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 is required to report to the Congress by July 1985 on any changes that have occurred. The report is 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.

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. The findings from a number of the studies are expected to be reflected in the reports.

DEFRA 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 OTA report, which was submitted in February 1986, examined four alternative Medicare payment policies: modifications to the current payment system, fee schedules, paying for packages of services, and capitation. The report noted that the effects of each strategy are difficult to predict, because of the uncertainty regarding physicians' behavior and the changing medical marketplace. The report suggests that the policy options that involve the least amount of change from the current payment methodology or that call for research and demonstration could be implemented within 1 to 2 years. These policy options include: reducing the number of payment codes, instituting volume controls, and mandating assignment. Fee schedules based on historical charge data could also be implemented in the near future. However, other types of reforms, such as universal capitation, resource based relative values scales, and payments for some types of packages or bundles of services (such as physician DRGs) may require further research and demonstration before they could be implemented.

COBRA required the Secretary, with the advice of the newly established Physician Payment Commission, to develop a relative value scale (RVS) for physician payments. P.L. 99-509 defers the date the Secretary is required to report on the RVS to July 1, 1989. The potential application date of the RVS is deferred until after Dec. 31, 1989.

P.L. 99-509 also required the Secretary to study and report to Congress by July 31, 1987 concerning the design and implementation of a prospective payment system for payment under Part B for radiology, anesthesiology, and pathology (RAP) services furnished to hospital inpatients. The report is to include data from a representative sample showing, for discharges classified within each diagnosis-related group (DRG), the distribution of total reasonable charges and costs for each inpatient discharge.



LEGISLATION

H.Con.Res. 30 (Kolter et al.)/S.Con.Res. 15 (Heflin, et al.)

Expresses sense of Congress that no major change in the payment methodology for physicians' services, including services to hospital inpatients, should have been made until reports required by 99th Congress are received and evaluated. H.Con.Res. 30 introduced in House on Jan. 22, 1987. S.Con.Res. 15 introduced in Senate on Feb. 5, 1987.

S.Con.Res. 56 (Durenberger, et al.)

Expresses sense of Congress that no significant changes in payment methodology for physicians' services, including services to hospital inpatients should be undertaken until results of reports required by 99th Congress are received and analyzed and Congress has considered advantages and disadvantages of possible solutions. Introduced. Introduced May 1, 1987; referred to Committee on Finance.

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Medicare reimbursement for physician services.  
Hearings, 99th Congress, 2d session. Apr. 14, 1986.

U.S. Congress. Senate. Committee on Finance.  
Medicare's physician payment system. Hearings,  
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#### CHRONOLOGY OF EVENTS

- 01/05/87 -- President submitted FY88 Budget.
- 10/21/86 -- President signed into law (P.L. 99-509) the Omnibus Budget Reconciliation Act of 1986.
- 04/07/86 -- President signed into law (P.L. 99-272) the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
- 07/18/84 -- President signed into law (P.L. 98-369) the Deficit Reduction Act of 1984.
- 04/20/83 -- President signed into law (P.L. 98-21) the Social

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