

prevailing fees. Use of the MEI to limit increases in prevailing fees has weakened the link to physicians' actual charges for those physicians whose claims are at the ceiling set by MEI-adjusted prevailing fees, but in 1984 less than half of approved charges were at that ceiling.

Under the CPR system, as in any fee-for-service payment system, physicians have no financial incentives to limit the volume of services they provide to their patients, because each service provided increases physicians' net incomes (so long as payment rates are high enough to cover incremental costs). In a fee-for-service system, the financial incentives that physicians face intensify the effects of their training, which teaches them generally to provide all services that might be of any benefit to their patients, regardless of costs. Although part of the increased volume of services provided per enrollee that has occurred since Medicare's inception has been a desirable response to the greater needs of an aging population, aided by remarkable improvements in medical technology, some increases may have been motivated more by physicians' attempts to maintain revenues in the face of fee constraints or insufficient patient-initiated demand for services than by expected benefits for patients. In addition, some increased volume of services per patient may be defensive medicine that has little benefit for patients but serves to protect physicians in the event they are sued for malpractice.

The structure of fees that has evolved under the CPR system may also distort physicians' behavior in undesirable ways. Unless payment rates reflect the costs of providing services, physicians have financial incentives to provide services that have relatively high profit margins. Many analysts believe that the current fee structure encourages physicians to provide procedural care over nonprocedural or "cognitive" care, because diagnostic and therapeutic procedures are reimbursed more generously relative to costs than are visits; to train for a specialty rather than for primary care, because current specialty differentials in Medicare's payments are larger than required to compensate for the additional training costs; and to practice in metropolitan areas rather than smaller cities and rural areas, because location differentials are larger than necessary to account for cost differences.

Cost-sharing by enrollees was intended to help contain Medicare costs, but the potential for cost-sharing to contain costs is quite limited for several reasons. About 80 percent of Medicare enrollees have supplementary health insurance coverage that reduces or eliminates their cost-sharing liabilities. Further, although those who face out-of-pocket costs for medical care reduce the number of physicians' visits they initiate, once an episode of care has been initiated the number and type of physicians' services consumed during the episode are not much affected by cost-sharing.

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Finally, physicians who have fewer patient-initiated visits apparently respond by providing more services to the patients they see.

### ALTERNATIVE APPROACHES

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The Congress has requested a number of studies on alternatives to the CPR system, with a view toward implementing payment methods that would incorporate better incentives for physicians to contain health care costs. This paper discusses three approaches:

- o Fee schedules;
- o Case-based payments (like the prospective payment system for hospital reimbursement); and
- o Capitated payments--fixed payments per enrollee for all covered medical services during a specified period of time.

Options for transforming the CPR system into a fee schedule are emphasized in this study, for two reasons. First, a fee schedule is the most feasible approach to implement in the near term, and it would not prevent more fundamental changes in payment systems in the future. Second, a fee schedule would likely be necessary even if other payment methods were adopted, both as a foundation for the more comprehensive payment rates and as a residual payment system for services or population groups not covered by the other systems. Either case-based or capitated payment systems, in which prospective payments are made for comprehensive packages of services, might become an important part of Medicare's payment methods in the long run. They are largely untried at this time (at least for the Medicare population), however, and evaluation of both the appropriate methods for implementing such systems and the likely effects would be useful.

#### Overview of Alternatives

Under any of the alternatives discussed in this paper, Medicare could play a more active role in setting payment rates than it does currently under the CPR system. The alternatives differ in the incentives they would create for limiting the volume of services and in the attendant risks of inadequate care for patients.

A fee schedule would, like the CPR system, be a fee-for-service payment method, in which physicians would have incentives to provide a high

volume of services. Controls on use of services therefore would likely be necessary to limit growth in volume and resulting cost increases. Under case-based and capitated payment systems, by contrast, fixed payments per service package would be made regardless of the actual services provided, giving physicians incentives to limit services, at least within the package. In packaged approaches, however, quality of care might be affected adversely if physicians responded to incentives to limit services by eliminating medically necessary care as well as services with little or no benefit. Since appropriate medical care is in many cases a matter of judgment, some physicians might err by providing too few services under packaged payment systems, while they may provide unnecessary services in fee-for-service payment systems. In addition, because confidence in one's physician can improve the outcome of treatment, patients could be adversely affected--even when provided all necessary services--if patients began to doubt their physicians because of perceived conflicts between their own desires for additional services and their physicians' financial interests to forgo them if not medically necessary.

Despite widespread dissatisfaction with the CPR system, some of its problems could be attenuated if the Congress wanted to retain it for the interim while more fundamental changes were developed, as has been proposed by the Administration. Prevailing fees for selected services that were thought to be unreasonably priced could be reduced without regard to customary charges for those services. Volume of services might be better controlled by expanding and improving the very limited review of service patterns that is currently done. Finally, the system could be simplified by reducing the number of specialties and payment localities with separate payment rates. These activities would probably increase administrative costs, however, and no provision for such cost increases has been made in the Administration's budget request for fiscal year 1987.

### Fee Schedules

Under a fee schedule, payment rates could be set for each service that were uniform for all physicians, or for all physicians in a given specialty and location. Physicians would be paid the same amount for a given service, in contrast to the CPR system in which each physician may be paid a different amount.

Payment rates under the CPR system are evolving into a set of specialty- and location-specific fee schedules anyway, because of the effect of the limit imposed on increases in prevailing fees by the MEI. Since physicians' customary fees have been increasing more rapidly than the MEI, eventually only MEI-adjusted prevailing fees will be relevant. But this is

not likely to occur until sometime in the next century. Further, the fee schedules that will evolve under the CPR system will reflect the structure of physicians' actual charges during 1971, because MEI-adjusted prevailing fees are simply Medicare's prevailing fees for June 1973 (which were based on charges for calendar year 1971) inflated by increases in the MEI since that time. The relationship between fees in 1971 is unlikely to be appropriate for pricing services now.

Instead of accepting the schedules that will evolve under the CPR system, the Congress could mandate development of a fee schedule. Implementation could perhaps take place within a year of the mandate if the schedule were initially based primarily on Medicare's average allowed amounts or submitted charges. Replacing the CPR system with a fee schedule would cut the inflationary link between physicians' charges and Medicare's payment rates, but a charge-based fee schedule would incorporate elements of the current fee structure that many people believe need to be corrected. The rate structure could be modified incrementally after it had been put in place, or changes in methods for reimbursing physicians could be delayed until a more appropriate fee structure was developed. (As part of the Consolidated Omnibus Budget Reconciliation Act of 1985, the Congress instructed the Secretary of the Department of Health and Human Services to develop, by July 1, 1987, a relative value scale for physicians' services, which could serve as the basis for a fee schedule.)

Decisions would need to be made at the outset about what differentials by specialty and location to incorporate. Although the higher costs of specialty training would justify higher payment rates on a cost basis, specialty differentials might be unnecessary to ensure enrollees' access to care under current circumstances because most specialties are thought to be in oversupply. Differentials by location could be set to reflect geographic cost differences, adjusted where necessary to ensure enrollees' access in all parts of the country.

Although reimbursement under a fee schedule would be on a fee-for-service basis, so that physicians' incentives to provide a high volume of services would remain, there are methods to control volume in fee-for-service payment systems. Claims data could be used to construct practice profiles for each physician, which could be monitored for evidence of excessive or inappropriate billing. (This is done now, to a very limited extent, but it is generally acknowledged that current methods could be greatly improved.) In addition, annual increases in payment rates could be inversely related to volume increases per enrollee, so that growth in Medicare's costs per enrollee could be capped as specified by the Congress regardless of volume increases. If this method caused Medicare's payment rates to fall much below rates approved by other payers, though, pressures

to increase payment rates would likely arise--despite the spending cap--in order to maintain enrollees' access to care.

### Case-based Payments

In a case-based payment system, the unit of payment would be the case or condition during a defined episode of care. All covered physicians' services related to the condition and provided during the episode could be included in a single payment amount, regardless of the actual services rendered. Payments made on a per case basis would probably have to be limited to hospital inpatient episodes, however, because of the difficulty of defining unambiguous episodes for ambulatory care.

One case-based option would be to package all physicians' services for inpatient episodes, just as all hospital services are packaged now under the prospective payment system. The primary advantage of this approach would be that physicians would have incentives, now lacking, to limit their own services and the services of consulting physicians for each episode, because use of more physicians' services would increase costs but not revenues.

This approach also has a number of disadvantages. Implementation would not be feasible until a case-classification system suitable for physicians' services had been developed, since at least some modification of the system of diagnosis-related groups (DRGs) currently used to classify cases for hospital reimbursement would be necessary. Further, case-based payments for physicians' services would require radical changes in the way physicians are paid. First, assignment of benefits (that is, acceptance by physicians of Medicare's approved charges as payment in full) would probably have to be mandatory; otherwise, patients would be effectively denied the protection insurance is intended to provide. Given the choice, physicians might refuse assignment for patients whose care was expected to cost more than the case payment, making the patient fully liable for any costs above that payment. Second, payments would probably have to be pooled for groups of physicians--for each hospital's medical staff, for example. If, instead, case payments were made to the primary physician to disburse to other physicians on each case, the financial risks for primary physicians would probably be so great that physicians would refuse to accept potentially "unprofitable" patients. Pooling payments would reduce the financial risks but would also weaken the desired incentives of the payment system, reducing the effect on the behavior of individual physicians. Another disadvantage is that paying primary physicians on a case basis could align their incentives too closely with those of hospitals under the PPS, with the result that physicians might not serve as effectively as advocates for their patients. Consequently, the need for Medicare to monitor the quality

of care provided would increase. Finally, separate payment systems for inpatient and ambulatory care would create the potential for physicians to manipulate the reimbursement system to maximize receipts. For example, services normally provided during an admission might be shifted to the office either before or after the hospital admission, so that claims made for ambulatory services would have to be closely monitored to ensure that Medicare did not pay for services that were intended to be included in the case payment.

A more limited case-based payment option would expand the services included in hospitals' case payments to include patient-related services provided by hospital-based physicians such as radiologists, anesthesiologists, and pathologists. These supporting physicians are commonly employed by or under contract to hospitals anyway, so that the proposed payment method would not be a radical change for many of them. Under this option, hospitals would have incentives, now lacking, to negotiate low-cost rates for these physicians and to use their services more efficiently. This approach, however, could put some physicians--especially those in small communities with only one hospital--in a disadvantageous bargaining position. Further, the potential savings from this approach would be smaller than savings under the option that would include all physicians' inpatient services in the case payment. Inpatient services provided by radiologists, anesthesiologists, and pathologists account for about 10 percent of total physicians' charges under Medicare, while inpatient services provided by all physicians account for about 60 percent of total physicians' charges.

### Capitated Payments

Under a capitation approach, Medicare would pay a fixed amount per enrollee to organizations that would, in return, provide or pay for all covered medical services to enrollees. These organizations would profit if enrollees could be served for less, but would lose if expenses per person exceeded Medicare's payments. The agencies at risk would have no financial incentive to provide unnecessary services, since they would receive no extra revenue from doing so; instead, they would have incentives to provide the least expensive set of services that would deal with enrollees' medical needs and to produce those services as efficiently as possible.

Studies of non-Medicare population groups have shown that good health care can be provided under capitated payment systems at costs that are about 25 percent below costs in the fee-for-service sector. Health care may be better coordinated under capitated payment systems, because central records are maintained and incentives exist to provide the most cost-effective mix of services, including preventive care. On the other

hand, patients may be restricted both in their choice of physicians and in the services that are provided to them. Savings under capitated payment systems found for other population groups, however, might not be as large for the Medicare population. Studies of other population groups that compared capitated payment systems with fee-for-service systems found that most savings under capitated payment plans resulted from lower use of the hospital. But the prospective payment system--together with Medicare's preadmission review requirements--already limits use of the hospital by Medicare enrollees. Some additional Medicare savings could result from capitation, though, because there would be financial incentives to reduce all unnecessary medical services, while under the PPS the financial incentives work only to reduce the length of hospital stays but not to reduce hospital admissions or physicians' services.

The organizations at risk under a capitated payment system might be prepaid medical plans (PMPs) that combine the roles of insurer and health care provider, or they might be traditional insurers who arrange for others to provide all covered health care services. Capitated payments to PMPs for Medicare enrollees are already permitted under law, and the Administration has proposed to expand this option to include traditional insurers as well. Areawide capitation plans that would cover all Medicare enrollees in a geographic area also are under consideration by the Administration.

Under current law, all Medicare enrollees have the option of joining a prepaid medical plan, but as yet less than 5 percent has done so. Medicare's capitation payments to these plans are set at 95 percent of the average per capita cost of benefits provided on a fee-for-service basis in the same community to enrollees with similar characteristics. Both enrollees and PMPs currently benefit from expanded Medicare enrollment, since PMPs' costs are generally below Medicare's capitated payments, and part of the resulting profits to PMPs must be returned to enrollees in the form of reduced copayments or supplemental benefits to the standard Medicare package. Profits to PMPs arise partly from their greater concern for cost-conscious care compared with fee-for-service providers, but may also result in part from the plans' selection of Medicare enrollees who are healthier than average. If such biased selection is prevalent, Medicare's costs for PMP enrollees could be higher than they would be if all enrollees received care in the fee-for-service sector.

Enrollment in prepaid medical plans is unlikely to be large enough to make capitation the dominant form of payment for Medicare enrollees so long as they are free to choose between capitated and fee-for-service care, because the former restricts their choice of physicians. In order to expand the number of Medicare enrollees who choose to opt out of the standard Medicare program in favor of a capitated alternative, the Administration

has proposed to permit enrollees to use a voucher (the value of which would be set in the same way capitation rates to PMPs are set) to purchase traditional indemnity insurance. Qualified plans would have to provide a benefit package that was actuarially equivalent, but not necessarily identical, to the standard Medicare package. Medicare enrollees thus would have choices about the benefit package that they do not have now. Retired enrollees with employer-based insurance coverage, for example, might be able to use the voucher to supplement benefits already provided by their employer-based plans, thereby avoiding duplicative coverage and obtaining a single package that better suited their needs. Some Medicare enrollees without employer-based coverage might also choose the voucher option, if alternative insurance coverage could be purchased through membership groups that would reduce insurers' marketing costs. (If insurers had to market directly to individuals, the plans offered would probably not be attractive compared with the standard Medicare package, because premiums would have to be substantially higher than expected benefits to cover marketing costs.)

Expanding Medicare enrollment in capitated payment systems may not be advisable, however, until improved methods of setting capitation rates have been developed, thereby reducing insurers' incentives for biased selection. Because the current method for setting rates does not adequately account for differences among types of enrollees in the costs of providing medical care, traditional insurers, like PMPs, would have incentives to seek to attract only healthier enrollees, leaving more costly enrollees in the standard Medicare program. If this biased selection occurred, Medicare costs would be higher than if all enrollees were served in the standard program, because the fee-for-service costs on which capitation rates are currently based would reflect the services used by high-cost Medicare enrollees, while PMPs and other insurers with Medicare enrollees would be serving relatively low-cost patients.

Another alternative that might bring all Medicare enrollees under a capitated payment system--one with fewer problems associated with biased selection--is "carrier capitation." (A carrier is an agency, usually an insurer, that is paid to process claims under Part B of Medicare and to disburse payments within a given jurisdiction, such as a state.) Under this system, carriers would be paid a fixed amount for each Medicare enrollee in their jurisdictions and would be required to negotiate with health care providers to ensure that enrollees could obtain all covered services. They would have financial incentives that carriers now lack to obtain discounts from providers and to institute comprehensive utilization review programs. The federal role would become one of awarding contracts to carriers and monitoring their performance to ensure that conditions specified in their contracts were fulfilled.

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This approach would present at least two major concerns, however. First, establishing contract language and monitoring mechanisms that would ensure that enrollees' access to and quality of care were not eroded could prove difficult. Continuation of the current Medicare program as one option that carriers must offer could serve as a safeguard for enrollees, but would also increase carriers' financial risks, so that fewer organizations would compete for the contracts, and contract costs would likely be higher. Second, areawide capitation contracts could give too much market power to the carriers selected. While this market power could be used for the benefit of Medicare enrollees by enabling carriers to negotiate substantial discounts with providers, thereby reducing enrollees' out-of-pocket costs, it could also be used to eliminate potential competitors for future Medicare capitation awards. As a result, the federal government might have no other organizations to turn to if the original carriers failed to perform acceptably.

## CHAPTER I

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# INTRODUCTION AND BACKGROUND

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The Medicare program is one of the largest items in the federal budget, and one of the fastest growing. In fiscal year 1985, net spending for Medicare was \$65.8 billion and accounted for 7 percent of total federal outlays. Under current law, Medicare is expected to grow at an annual rate of 11.3 percent, to more than 9 percent of federal outlays by 1991. Part B of Medicare, which pays for physicians' services, is expected to grow more rapidly than the rest of Medicare, at an annual rate of 14.7 percent from fiscal year 1986 through 1991.

Congressional concern about the effects of Medicare costs on the federal budget is high, but there is also concern about effects on Medicare enrollees of their payments for out-of-pocket medical expenses and for health insurance premiums.<sup>1/</sup> Although the share the elderly pay of their health care costs, either directly or through insurance premiums, has declined a little in recent years--from 40 percent in 1977 to 37 percent in 1984--health care payments claim a larger share of their incomes now because of increased overall costs.<sup>2/</sup> In 1984, out-of-pocket costs plus insurance premiums for health care paid by the elderly exceeded \$1,500 on average--about 15 percent of personal income. This proportion has increased from 12 percent in 1977 and is now about the same as in 1966, before Medicare was implemented.<sup>3/</sup>

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1. Out-of-pocket costs are the share of charges for specific services paid by the patients. They include deductible and coinsurance amounts on approved charges, as well as any billed amounts in excess of the insurer's approved rates. Premiums paid for insurance are not included in the definition of out-of-pocket costs used here.
  2. The share paid by the elderly has declined slightly because the share of Medicare costs financed by premiums has decreased and the Part B deductible has fallen as a proportion of average per capita benefits. Other copayments have increased.
  3. See *Medicare and the Health Costs of Older Americans: The Extent and Effects of Cost Sharing*, S. Prt. 98-166, Special Committee on Aging, U.S. Senate, 98:2 (April 1984); and *America's Elderly at Risk*, Select Committee on Aging, U.S. House of Representatives, 99:1 (July 1985).

Further, Medicare's initial reimbursement methods were not designed to encourage cost-conscious behavior by health care providers. As a result, interest has focused on finding better ways to limit payments to health care providers. Major changes in Medicare's methods for reimbursing hospitals have already been made. This paper discusses alternative ways in which Medicare could reimburse physicians.

Although only about one-fourth of Medicare's reimbursements are for physicians' services, physicians direct the allocation of most Medicare spending because their authorization is necessary for hospital admission and for most medical tests. Consequently, any change in physicians' practice patterns induced by new payment methods could have a far greater effect on Medicare costs than the share spent directly on physicians' services would indicate. This, in turn, could have a substantial effect on general health care costs, since Medicare enrollees account for more than one-third of total health care spending in the United States.

This study discusses Medicare's current payment methods for physicians and examines the advantages and disadvantages of proposed alternatives. The study does not consider modifications to Medicare's benefit structure, such as altering coverage or cost-sharing provisions. The remainder of this chapter provides a brief description of the Medicare program and a discussion of ways in which the market for health care differs from other markets, with implications for Medicare's physician reimbursement policies.

Chapter II describes Medicare's current physician reimbursement methods and the associated problems. Chapter III provides an overview of proposed alternatives--including fee schedules, prospective payments per case or episode of care, and prepaid capitated payment systems. Chapter III also reviews the Administration's 1987 budget proposals for modifying--but retaining--Medicare's current physician payment methods in the short term, while preparing for more fundamental changes in the future.

Chapter IV examines fee schedule approaches while Chapters V and VI discuss, respectively, case-based and capitation approaches. The latter two are packaging options that might become important parts of Medicare's payment methods in the long run, but that are largely untried (at least for the Medicare population) at this time.

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## THE MEDICARE PROGRAM

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Medicare was enacted in 1965 and implemented on July 1, 1966. It is an insurance program that finances health care services for more than 27 million people age 65 and over and for another 2.7 million disabled people.

The Medicare program has two parts--Hospital Insurance (HI) under Part A, and Supplementary Medical Insurance (SMI) under Part B. Bills for inpatient hospital care, some stays in skilled nursing facilities, and home health services are paid by the HI program. The SMI program pays for physicians' services and for charges by hospital outpatient departments, independent medical laboratories, and other medical suppliers. About 80 percent of reimbursements under the SMI program (and 25 percent of total Medicare reimbursements) are for physicians' services.

The HI program is financed by a portion of the Social Security payroll tax levied on current workers. The SMI program is financed partly from premiums paid by enrollees (currently 25 percent) and partly from general revenues (75 percent).

### Eligibility

More than 95 percent of the elderly are eligible for HI benefits based on previous Social Security or Railroad Retirement payroll tax payments, and those who are not may purchase coverage by paying a monthly premium (\$214 in 1986). SMI coverage is available to all people age 65 and over with payment of a monthly premium (\$15.50 in 1986), and 97 percent of those with HI coverage also enroll in the SMI program. In addition to the elderly, disabled people entitled to Social Security cash benefits for at least 24 consecutive months and people with end-stage renal disease are eligible for Medicare benefits.

### Coverage and Cost-Sharing Requirements

Medicare is designed to cover primarily acute-care needs rather than to provide a comprehensive range of medical services. As such, it pays for slightly less than half of total health care costs for the elderly (see Table 1). The most important coverage exclusions are long-term nursing home care, outpatient drugs, and dental services, which account for about 30 percent of total health care costs for the elderly. <sup>4/</sup>

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4. *Medicare and the Health Costs of Older Americans*, Special Committee on Aging, U.S. Senate.

TABLE 1. EXPENDITURES FOR PERSONAL HEALTH CARE, FOR ALL AGE GROUPS AND FOR PEOPLE AGE 65 AND OLDER, BY SOURCE OF FINANCING AND TYPE OF SERVICE, 1984

Source of Financing	Type of Service					
	In Billions of Dollars			As a Percent of Total		
	All Care	Physicians	Hospitals	All Care	Physicians	Hospitals
<b>Personal Health Care for All Age Groups</b>						
Total Expenditures	341.8	75.4	157.9	100.0	100.0	100.0
Out-of-Pocket <u>a/</u>	95.4	21.0	13.7	27.9	27.9	8.7
Third Party	246.4	54.4	144.2	72.1	72.1	91.3
Private	111.0	33.5	59.9	32.5	44.4	37.9
Government	135.4	20.9	84.3	39.6	27.7	53.4
Medicare	63.1	14.6	44.4	18.5	19.4	28.1
Medicaid <u>b/</u>	36.7	3.1	14.1	10.7	4.1	8.9
Other	35.6	3.2	25.8	10.4	4.2	16.3
<b>Personal Health Care for People 65 and Older</b>						
Total Expenditures	119.9	24.8	54.2	100.0	100.0	100.0
Out-of-Pocket <u>a/</u>	30.2	6.5	1.7	25.2	26.2	3.1
Third Party	89.7	18.3	52.5	74.8	73.8	96.9
Private	9.2	3.4	4.5	7.7	13.7	8.3
Government	80.5	14.9	48.0	67.1	60.1	88.6
Medicare	58.5	14.3	40.5	48.8	57.8	74.8
Medicaid <u>b/</u>	15.3	0.5	2.6	12.8	1.9	4.8
Other	6.7	0.2	4.9	5.6	0.7	9.1

SOURCES: Compiled by Congressional Budget Office from data reported in Katharine R. Levit and others, "National Health Expenditures, 1984," *Health Care Financing Review*, vol. 7, no. 1 (Fall 1985), Tables 3 and 8; and in Daniel R. Waldo and Helen C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-1984," *Health Care Financing Review*, vol. 6, no. 1 (Fall 1984), Table 11.

- a. Excludes insurance premiums.  
 b. Includes Medicaid purchase of Medicare coverage for Medicare-eligible recipients.

Remaining health care costs not reimbursed by Medicare occur because of Medicare's cost-sharing requirements. Medicare's copayment requirements in the HI program for 1986 included a first-day deductible of \$492 for hospital stays, coinsurance of at least \$123 a day for hospital stays exceeding 60 days, and coinsurance of \$62.50 a day for stays in skilled nursing facilities exceeding 20 days. In the SMI program, Medicare enrollees are responsible for 20 percent of all approved physicians' charges above an annual deductible amount (\$75 in 1986). In addition, they are liable for 100 percent of any charges in excess of Medicare's approved rates if their physicians do not accept assignment of benefits. Physicians who accept assignment agree to accept Medicare's approved rates, in return for Medicare's guarantee of payment directly to the physicians for 80 percent of approved charges once the deductible amount is exceeded. (Physicians must still bill patients for deductible amounts and for the 20 percent coinsurance.) By rejecting assignment, physicians can charge enrollees more than approved Medicare rates (a practice known as balance-billing), but then reimbursement is made to patients, and physicians have no guarantee that billed amounts will be collected.

#### Supplements to Medicare's Coverage

Charges for services not covered by Medicare and copayments required by Medicare for covered services are generally paid by Medicaid for Medicare enrollees who qualify. Medicaid is the federal/state health insurance program that serves about 40 percent of the poor population. More than 10 percent of Medicare enrollees nationwide are Medicaid beneficiaries, although eligibility conditions vary by state. 5/

In addition, about 70 percent of Medicare enrollees have private supplementary insurance coverage, or "medigap" policies. This insurance usually covers the coinsurance and some of the deductible payments required under Medicare for covered services, but in many cases does not pay for services not covered by Medicare. For example, costs for long-term care in a nursing home are rarely covered, and physicians' charges in excess of Medicare's approved rates are covered for only about half of medigap policyholders. 6/

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5. About 9 percent of Medicare enrollees are people with low incomes for whom state Medicaid programs purchase SMI coverage by paying the SMI premium, a transaction called a buy-in. Some other Medicare enrollees qualify at some time during the year for Medicaid benefits under Medicaid's "medically needy" provisions. These people have incomes too high to be eligible for Medicaid benefits normally, but have incurred very large medical costs relative to their incomes.
  6. National Center for Health Services Research, "Private Health Insurance Coverage of the Medicare Population," National Health Care Expenditures Study, Data Preview 18, September 1984.

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Costs and Cost-Control Efforts in Medicare

The primary concern when the Medicare program was enacted was to provide access to care for the nation's elderly population.<sup>7/</sup> Although the need for health care typically increases with age, before Medicare many elderly people were unable to obtain private health insurance at reasonable cost after retirement. In order to gain acceptance for the program, Medicare reimbursed health care providers on the basis of their costs (for hospitals) or their customary charges (for physicians). Medicare was a passive payer initially, and made no attempt to negotiate fees or to control use of services. Since hospitals were reimbursed for whatever costs they incurred, they had little incentive to seek more cost-effective ways of providing care. Because physicians were paid on the basis of their customary charges for whatever services they provided, they had incentives both to increase their fees and to provide a high volume of services.<sup>8/</sup>

Unexpectedly rapid growth in Medicare costs led quickly to the introduction of cost-control provisions, beginning with the Social Security Amendments of 1972. Early efforts included peer review of hospital admissions, limits on above-average costs per day for hospital stays, and cost-based limits on the rate of increase in payment rate ceilings for physicians. Despite these cost-control provisions, Medicare costs continued to increase rapidly. Total reimbursements per enrollee grew at an annual rate of 15.5 percent between 1975 and 1982--7.2 percentage points higher than the rate of economywide inflation (see Table 2).<sup>9/</sup>

More stringent cost-control measures have been enacted recently. For hospitals, limits on annual increases in operating costs per discharge were imposed in 1982; and in 1983, retrospective cost-based reimbursement for inpatient services was replaced by the prospective payment system (PPS). Under the PPS, hospitals are paid a fixed amount per admission, based on each patient's diagnosis at the time of discharge. Initially, 468 diagnosis-related groups (DRGs) were defined for payment. Since reimbursement is the same regardless of the services provided to the patient, hospitals have a financial incentive to reduce the patient's length of stay and the costs of services provided during the stay, within the limits of acceptable medical practice. No fundamental change has yet been made in Medicare's payment

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7. Coverage for the disabled began later, on July 1, 1973.
  8. Throughout this paper, volume increases are defined to include increases in the number of services provided, increases in their general level of complexity, or increases in both.
  9. The base year used is 1975 because economywide wage-price controls were in effect from 1971 through 1974.

methods for physicians, but the annual update in reimbursement rates that would normally have been made on July 1, 1984, was eliminated. Rates for all physicians were initially frozen until October 1, 1985. The freeze was later extended until May 1, 1986, for physicians who sign participating agreements with Medicare, thereby consenting to accept Medicare's payment rates. For other physicians, the freeze was extended until January 1, 1987.

As a result of recent cost-control measures, together with a decline in the rate of general inflation, the rate of growth in Medicare's costs per enrollee dropped to 7.5 percent for 1984--about half the average rate of growth from 1975 through 1982. In constant dollars, Medicare reimbursements per enrollee grew by only 3.2 percent for 1984--the lowest rate of growth since the early 1970s.

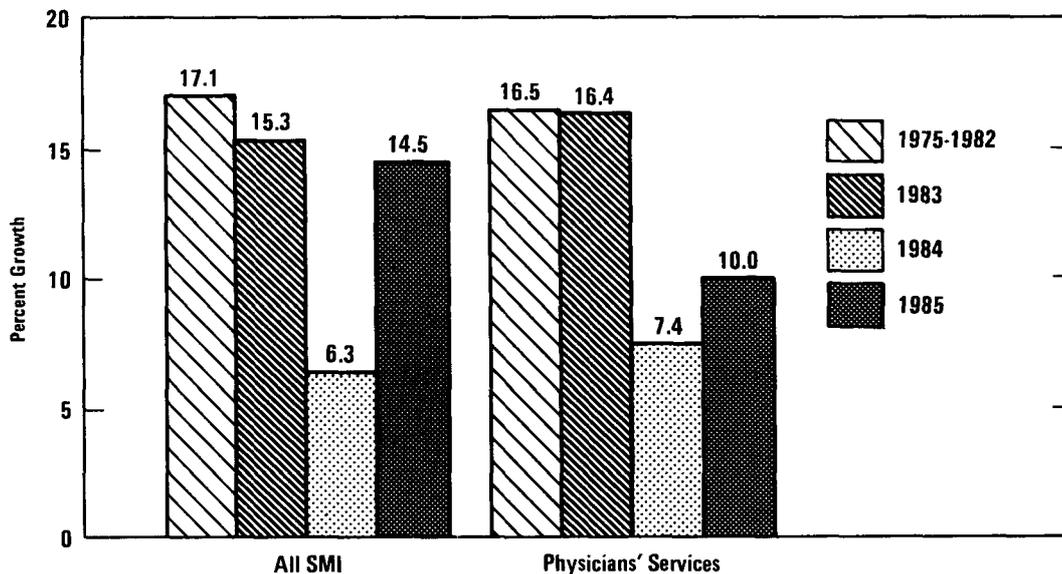
TABLE 2. ANNUAL RATES OF GROWTH IN REIMBURSEMENTS UNDER MEDICARE, 1975-1985 (In percents)

Reimbursements	1975-1982	1983	1984	1985
<b>Hospital Insurance</b>				
Total Reimbursements	17.8	10.4	10.0	10.0
Per enrollee	14.9	8.6	8.0	8.2
In constant dollars <u>a/</u>	6.6	4.6	3.8	4.7
<b>Supplementary Medical Insurance</b>				
Total Reimbursements	20.2	17.2	8.6	16.7
Per enrollee	17.1	15.3	6.3	14.5
In constant dollars <u>a/</u>	8.7	11.1	2.1	10.8
<b>Total Medicare</b>				
Total Reimbursements	18.5	12.4	9.5	12.1
Per enrollee	15.5	10.6	7.5	10.1
In constant dollars <u>a/</u>	7.2	6.6	3.2	6.6

SOURCE: Congressional Budget Office, from data provided by the Health Care Financing Administration.

a. Reimbursements per enrollee after eliminating the effects of general inflation, as measured by the gross national product (GNP) deflator.

Figure 1.  
**SMI Reimbursements Per Enrollee, Annual Growth Rates, 1975-1985**



SOURCE: Congressional Budget Office from data provided by the Health Care Financing Administration.

In 1985, however, growth rates increased, especially for the SMI program. A significant part of the jump in SMI costs for 1985 (and the slowing of cost growth for 1984) was caused by billing changes for nonphysician services (hospital outpatient departments and laboratories).<sup>10/</sup> Costs for physicians' services followed a similar (but less extreme) pattern, although for different reasons (see Figure 1, above). Because physicians' payment rates were frozen throughout 1985, the increased growth in spending for physicians' services apparently resulted from increased growth in volume, although this conclusion is speculative at this time.<sup>11/</sup>

10. Beginning in mid-1984, SMI payments for laboratory services were set by fee schedules, at 60 percent to 62 percent of then-prevailing charges. This reduced laboratory charges overall for the SMI program, and also required hospital outpatient departments to switch from a cost-basis to a fee schedule for reimbursement of laboratory services. As a result of the change in methodology, there were delays in Medicare payments to hospital outpatient departments for the last half of 1984 and early 1985.

11. A study of the extent of volume increases during the freeze on physician fees has been funded by the Health Care Financing Administration, with results expected by 1988.