
PROBLEMS WITH THE CPR SYSTEM

The CPR system is widely thought to be unsatisfactory.^{14/} A major problem is that it encourages increases in both the price and the volume of services, with resultant increases in costs for the Medicare program and for Medicare enrollees. A second problem is that fee differentials resulting under the CPR system may affect the health system in undesirable ways, by encouraging inappropriate treatment patterns and overspecialization by physicians. Other problems attributed to it are that it is administratively complex and confusing for both physicians and patients.

Poorly Designed to Constrain Costs

Both the price and the volume of services must be controlled to constrain costs, and the CPR system is weak on both counts. Fee increases are encouraged because Medicare's payment rates in one year are based on physicians' actual charges in the previous year for physicians whose customary fees are below Medicare's prevailing fees.^{15/} Increases in the volume of services provided per enrollee are encouraged because the CPR system reimburses on a fee-for-service basis. Physicians have incentives--offset to some degree by concern about patients' costs--to provide all services of any potential benefit so long as payment rates are high enough to cover the incremental costs of providing the services.

Cost-sharing by patients should help to limit both fee increases and the volume of services, but the effect of these requirements is diluted by the prevalence of supplemental insurance coverage for Medicare enrollees. As discussed in Chapter I, about 70 percent of Medicare enrollees purchase medigap coverage, while more than 10 percent of enrollees are Medicaid beneficiaries.

Studies cited in Chapter I indicate that the primary effect of cost-sharing for the 20 percent of Medicare enrollees without supplemental

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14. Criticisms of the CPR system could apply equally to UCR reimbursement in private insurance programs. CPR-UCR reimbursement methods were rare until adoption by Medicare. At that time, many of the insurance companies chosen as Medicare carriers--principally Blue Shield plans--adopted CPR-UCR methods for their private plans as well, partly to facilitate administration. Hence, replacement of Medicare's CPR system might lead to related changes in private reimbursement methods.
 15. Donald E. Yett and others, "Fee Screen Reimbursement and Physician Fee Inflation," *Journal of Human Resources*, vol. 20, no. 2 (Spring 1985), pp. 278-291.

TABLE 9. PRACTICING PHYSICIANS IN THE UNITED STATES, SELECTED YEARS

| | 1950 | 1960 | 1970 | 1980 | 1990 <u>a/</u> | 2000 <u>a/</u> |
|-------------------------|---------|---------|---------|---------|----------------|----------------|
| Physicians | 219,900 | 259,400 | 326,500 | 457,500 | 594,600 | 706,500 |
| Per 1,000 Population | 1.41 | 1.40 | 1.56 | 1.97 | 2.38 | 2.64 |

SOURCE: Congressional Budget Office from data in Department of Health and Human Services, *Health, United States, 1984*, Table 60.

a. Projected.

coverage comes through the disincentive to initiate an episode of care; once initiated, decisions about further care are influenced by physicians so that the effect of cost-sharing by patients is reduced. A physician whose patient load is low may provide more intensive (and expensive) care--longer office visits, additional follow-up visits, or more tests, for example--than one with a heavy patient load. ^{16/} Consequently, growth in the number of physicians per capita, which has resulted in smaller patient loads on average, may have increased the services used per Medicare enrollee in recent years (see Table 9, above). In addition, as discussed in Chapter I, physicians tend to increase the volume of services for which they bill in response to constraints on the level of their fees. Some growth in volume per enrollee may result from the increasing constraint imposed by use of the MEI to limit increases in prevailing fees, as Medicare's approved rates for a growing proportion of physicians' charges have been set by MEI-adjusted prevailing fees rather than by physicians' customary fees. Finally, many people believe that the increasing threat of malpractice suits has caused physicians to practice more service-intensive care as a defense.

Not all growth in the volume of services in the past was undesirable, however. The average age of the Medicare population has been increasing, and the need for medical services typically increases with age. In addition, remarkable advances in medical technology have been made in recent years, including improved surgical techniques for cataracts, techniques to alleviate the pain associated with clogged arteries supplying the heart, and pro-

16. See Gail R. Wilensky and Louis F. Rossiter, "The Relative Importance of Physician-induced Demand in the Demand for Medical Care," *Milbank Memorial Fund Quarterly*, vol. 61, no. 2 (1983), pp. 252-277.

cedures for successful replacement of major joints. As a result, both the need for medical services among the Medicare population, and the ability of physicians to respond to those needs, have expanded.

The net effect of the incentives for fee inflation and volume increases under the CPR system, together with the rising number of physicians per capita and recent medical advances, has been a higher rate of growth in Medicare's costs for physicians' services than can be explained by growth in Medicare enrollment and in general inflation. The rest of this section describes the historical growth in Medicare's approved charges and reimbursements for physicians' services.

Approved charges for physicians' services under Medicare grew at an average annual rate of 17 percent from July 1975 through June 1984.^{17/} The growth rate in approved charges per enrollee was 14 percent over this period--more than 7 percentage points higher than general inflation (see Table 10). Reimbursements for physicians' services grew even more rapidly than approved charges--nearly 19 percent over this period--because increases in the SMI deductible amount did not keep pace with increased charges.

About one-third of the growth in approved charges per enrollee resulted from greater volume of services (increases in either the number or the average complexity of services), while nearly two-thirds was caused by increases in approved rates. Almost 80 percent of the increase in approved rates, however, reflected general inflation in the economy. When the effects of general inflation are eliminated, one can see that volume increases contributed about 2.5 times as much as real fee increases to growth in costs per enrollee for physicians' services between 1975 and 1984 (Figure 2).^{18/}

In 1984, the growth of costs for physicians' services dropped substantially. Data on physicians' charges for all of 1984 are not yet available, but the rate of growth in reimbursements was nearly halved between calendar years 1983 and 1984 (see Table 11). Part of this drop was caused by the

17. The latest consistent data available on physicians' charges under Medicare were for the 1984 program year (July 1 - June 30) at the time of publication.

18. Fee increases are calculated for a fixed bundle of medical services, so that increases in the general complexity of services provided are included in the measure of service volume.

TABLE 10. ANNUAL RATES OF GROWTH IN APPROVED CHARGES FOR PHYSICIANS' SERVICES UNDER MEDICARE, PROGRAM YEARS 1975-1984 (In percents)

| Components of Growth | 1975-1984 |
|------------------------------|-----------|
| Approved Charges | 17.1 |
| Number of Enrollees | 2.3 |
| Charges Per Enrollee | 14.4 |
| Volume of services <u>a/</u> | 4.9 |
| Fee increases <u>b/</u> | 9.1 |
| Real fees | 1.8 |
| General inflation <u>c/</u> | 7.2 |

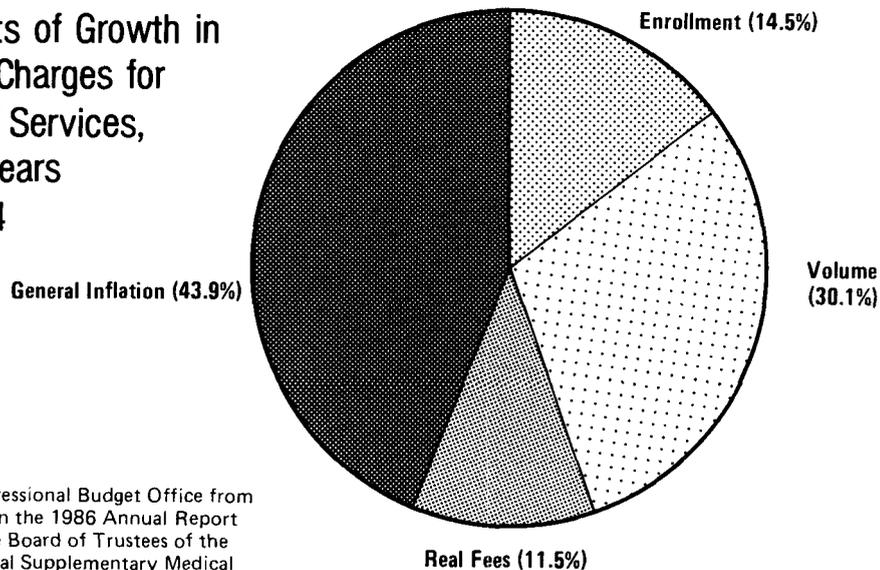
SOURCE: Congressional Budget Office from data in the 1986 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.

NOTES: Program years are from July 1 through June 30. Only enrollees age 65 or older are included in these numbers.

- a. Increases in either the number or the average complexity of services.
- b. Increases in fees approved by Medicare.
- c. As measured by the GNP deflator.

Figure 2.

Components of Growth in Approved Charges for Physicians' Services, Program Years 1975-1984



SOURCE: Congressional Budget Office from data in the 1986 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.

TABLE 11. ANNUAL RATES OF GROWTH IN REIMBURSEMENTS FOR PHYSICIANS' SERVICES UNDER MEDICARE, 1975-1985 (In percents)

| Reimbursements | 1975-1982 | 1983 | 1984 | 1985 <u>a/</u> |
|-------------------------------|-----------|------|------|----------------|
| Total Reimbursements | 19.5 | 18.2 | 9.8 | 12.1 |
| Per Enrollee | 16.5 | 16.4 | 7.4 | 10.0 |
| In Constant Dollars <u>b/</u> | 8.1 | 12.1 | 3.2 | 6.4 |

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

- a. Preliminary estimates.
- b. Reimbursements per enrollee after eliminating the effects of general inflation, as measured by the GNP deflator.

freeze on Medicare's payment rates effective July 1, 1984. In addition, it seems likely that recent cost-control measures directed at hospitals--the PPS and the new peer review procedures for hospital admissions--have helped to limit the volume of physicians' services. ^{19/}

In 1985, however, the rate of growth of costs for physicians' services increased despite continuation of the fee freeze throughout the year. This was apparently the result of accelerated growth in the volume of services, although it is difficult to disentangle the effects of the many changes that have been made in Medicare since 1982.

Inappropriate Effects on the Health Care System

Medicare's fee differentials by type of service, by physician specialty, and by location are the result of the evolution of payment rates under the CPR system, rather than of systematic determination. Unless payment rates for services reflect the costs of producing them, incentives exist for physicians

19. Hospitals were brought under the PPS during the year beginning October 1, 1983, according to the start of each hospital's fiscal year. Peer Review Organizations began operations on July 1, 1984.

to prefer to provide those services for which payment rates are high relative to costs. To the extent that existing differentials do not reflect costs, there may be undesirable responses by physicians--in their treatment patterns, their decisions to specialize, and their location decisions--although there is no strong empirical evidence for any of these effects.

Treatment Patterns. Fee differentials by type of service in Medicare are commonly perceived as creating financial incentives for unnecessary tests or for surgical and other procedural care over cognitive care, such as history-taking and discussion of methods by which patients might prevent or alleviate their own symptoms. For many medical problems, there is a range of diagnostic and treatment approaches consistent with accepted medical practice; however, little is known about the relative efficacy of many of these approaches. In such situations, some physicians may tend to recommend approaches that would be especially profitable for them.

In a neutral fee structure, fees would closely reflect the costs of the resources required to provide each service, so that physicians' choices would depend only on the effectiveness of the services and on patients' preferences. Required resources might include the physician's time (adjusted for skill) as well as space, equipment, supplies, and office staff that must be paid for by the physician. Resources actually used might be greater than the minimal set of resources necessary to deliver adequate service if, for example, uncomplicated procedures were performed by specialists, but many analysts would argue that payment rates should not allow for skills (or any other resources) that were not required.

Under the CPR system, however, some services are reimbursed more generously relative to costs than others. 20/ Procedures that have become routine or automated as a result of advances in technology are usually very profitable, because the rates established for them when they were introduced--and that may have been appropriate at the time--are not adjusted downward when the procedure becomes less costly to perform. Examples that have been cited include coronary artery bypass surgery, cataract surgery, pacemaker implants, electrocardiographs, and x-rays. 21/

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20. For example, one study indicates that, even after standardizing for complexity, physicians are paid four to five times as much per hour for surgery as for office visits. See W.C. Hsiao and W.B. Stason, "Toward Developing a Relative Value Scale for Medical and Surgical Services," *Health Care Financing Review*, vol. 1, no. 2 (Fall 1979), pp. 23-38.
 21. See M.S. Blumberg, "Provider Price Changes for Improved Health Care Use," in G.K. Chacko, ed., *Health Handbook* (Amsterdam: North-Holland Publishing Co., 1979). Medicare's approved charges for these services were \$3.8 billion in 1984 (exclusive of anesthesiologists' fees), so that savings from downward adjustment could be substantial.

Bypass surgery, for example, required extraordinary expertise and an enormous amount of the surgeon's time when it was first introduced. The cardiac surgeon was heavily involved from start to finish on a case, including diagnostic studies, preoperative preparations, the surgery itself, and postoperative care. Now, however, experience and improved methods have made the surgery simpler, faster, and less risky, while most of the pre- and postoperative care is provided (and billed) by other physicians.

Despite these changes, reimbursement rates initially set for the surgeon have been increased each year under the CPR system, rather than reduced to reflect the surgeon's decreased responsibilities. As a result, thoracic surgeons could receive about \$538,000 annually by performing three bypass operations each week, based on amounts allowed by Medicare for 1984. By one estimate, performing three bypass operations a week would represent a maximum time commitment of 12 hours weekly.^{22/} For comparison, internists would have to provide about 400 office visits each week to receive the same total allowed amounts annually from Medicare. This would mean that internists could spend no more than nine minutes with each patient, working 60 hours a week every week of the year.

Some analysts believe that Medicare's rates also favor hospital-based over office-based care, so that physicians have financial incentives to hospitalize patients for services that could be provided on an ambulatory basis. Rates for physicians' services other than visits are generally the same wherever the services are rendered.^{23/} But physicians' costs are probably lower for services provided in the hospital, because physicians do not bear the costs of overhead and support staff for hospital care as they do for office-based care. Such expenses account for about 40 percent of disbursements for an office-based practice. (The other 60 percent is net physician income.) In most cases, though, office expenses are unavoidable costs of maintaining a practice, because physicians must typically staff an

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22. B.B. Roe, "The UCR Boondoggle: A Death Knell for Private Practice?" *New England Journal of Medicine*, vol. 305, no. 1 (July 2, 1981), pp. 41-45.
 23. Currently, there are only two exceptions to this. For radiology, regulations limit reimbursement for interpretation services provided in hospitals (either inpatient or outpatient) to 40 percent of the prevailing charge for the total service (interpretation and the technical component) provided in an office setting. For nonsurgical services rendered in hospital outpatient departments that are routinely provided in physicians' offices, regulations limit physician reimbursement to 60 percent of the prevailing charge for that service when provided in an office setting.

office full-time even though some of their services are provided in the hospital. Consequently, spreading these office expenses across all services may be appropriate, whether services are provided in the office or the hospital. In the case of visits, Medicare's rates (for a given type of visit to a given physician) are typically 10 percent to 30 percent higher if the visits are in the hospital rather than the office.^{24/} Some difference in rates may be justified, however, by the more complex nature of the care generally needed by hospital patients compared with office patients; that is, office and hospital visits with the same name may not be the same in practice.^{25/}

Specialization. Education, like investments in property or financial assets, yields a return on the initial commitment of time or money because of the increased income received as a result of the investment. At least through 1983, the real rate of return to medical education was substantially higher than the return to training for other occupations requiring postbaccalaureate education, and the rate of return to specialization after obtaining a medical degree was also very high. Consequently, the fee structure provided financial incentives to obtain a medical degree and to specialize, despite projections of an oversupply of physicians in all but primary care specialties--general or family practice, general internal medicine, and pediatrics.^{26/} By one estimate, the real rate of return to medical education in 1983 was 16 percent, averaged across specialties.^{27/} The return for general practitioners was 11 percent, while the return for selected surgical and hospital-based specialties ranged from 16 percent to 22 percent (see Table 12).

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24. CBO tabulations from HCFA's 1984 Medicare Annual Data Provider file.
 25. Jack Hadley and others, "Final Report on Alternative Methods of Developing a Relative Value Scale of Physicians' Services," HCFA Contract 500-81-0053 (Urban Institute, Washington, D.C., October 1984), Table I-3, pp. 15-17.
 26. *Report of the Graduate Medical Education National Advisory Commission to the Secretary*, Department of Health and Human Services (1980).
 27. Frank Sloan and Joel Hay, "Medicare Pricing Mechanisms for Physicians' Services: An Overview of Alternative Approaches," *Medical Care Review*, vol. 43, no. 1 (Spring 1986). See also papers by Philip Burstein and Jerry Cromwell, "Relative Incomes and Rates of Return for U.S. Physicians," *Journal of Health Economics*, vol. 4, no. 1 (March 1985), pp. 63-78; and by Stephen Dresch, "Marginal Wage Rates, Hours of Work, and Returns to Physician Training and Specialization," in Nancy Greenspan, ed., *Issues in Physician Reimbursement* (Health Care Financing Administration, Pub. No. 03121, August 1981).

TABLE 12. REAL RATES OF RETURN TO MEDICAL EDUCATION,
BY SPECIALTY, 1983 (In percents)

| Specialty | Rate of Return to Training |
|----------------------------------|-------------------------------|
| All Physicians | 16 |
| General Practice/Family Practice | 11 |
| Internal Medicine | 14 |
| Pediatrics | 9 |
| Surgery | 19 |
| Obstetrics-Gynecology | 16 |
| Radiology | 20 |
| Anesthesiology | 22 |
| Pathology | 17 |
| Psychiatry | 13 |

SOURCES: Frank Sloan and Joel Hay, "Medicare Pricing Mechanisms for Physicians' Services: An Overview of Alternative Approaches," *Medical Care Review*, vol. 43, no. 1 (Spring 1986).

The rate of return to medical training may be lower in the future owing to reduced federal assistance for medical education and to increased competition for patients. The current high rate of return provides some assurance, though, that more stringent controls on fees and utilization of medical services could be introduced without reducing physicians' net incomes to such an extent that too few would choose to train for medical careers in future years.

For students who decide to obtain a medical degree, a neutral structure for physician fees (if all payers adopted it) would result in equal rates of return regardless of specialty, and medical students therefore would be financially indifferent to choice of specialty. Since specialty training takes longer, specialists would earn more for a given work year, but only by enough to compensate for their greater investment in training. This effect could occur even if all physicians were paid the same rate for each type of service rendered, since specialists would generally provide a more complex mix of services that would result in higher net income per year.

Location. The range in rates for specific services across Medicare's 240 payment localities is substantial, and it appears unlikely that these differences are an accurate reflection of differences in living and practice costs by location. One study of Medicare's 1975 prevailing fees for surgical procedures attempted to explain fee variations by differences in living costs, malpractice premiums, quality of care, and physician supply relative to population, with little success. Some of the variation was explained by living costs, but fees adjusted for living costs still varied threefold from one locality to another. None of the other factors considered in the study appeared sufficient to account for the remaining variation. 28/

Analysis of county data nationwide for 1984 showed that the correlation between Medicare's prevailing fees for a set of common services and an area wage index (the PPS wage index, used as a measure of physicians' costs) was often quite low. 29/ For general practitioners, the correlation ranged from .17 (for a cystoscopy) to .68 (for an office visit). For specialists, the correlation varied from .37 (for a cystoscopy) to .54 (for an office visit). 30/

Medicare's rates for visits (to internists for office visits by established patients) are 50 percent higher in urban areas than in rural areas, on average nationwide, while costs are only 23 percent higher, at least as measured by the PPS wage index. 31/ If Medicare's allowed amounts for visits are appropriate relative to costs nationwide, then allowed amounts in urban areas are 3 percent higher than necessary to account for cost differences, and in rural areas are 16 percent too low (see Table 13). It is uncertain whether the PPS wage index is appropriate for assessing differences in physicians' costs by location, however. It may adequately account for

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28. T. Bogue, *Why Not the Most? A Physician's Guide to Locating in Cities with the Most Excessive Medicare Fees in the Country and an HEW Guide to Stopping This Waste of a Billion Dollars* (Washington, D.C.: Health Research Group, February 1977).
 29. The PPS wage index is the hospital wage index used to adjust payment rates to hospitals by location under the prospective payment system. This index was developed by the Health Care Financing Administration from information on wages and hours worked obtained by surveying hospitals that treat Medicare patients. It is based on average hourly wage costs for full-time hospital employees, including residents and provider-based physicians.
 30. CBO analysis from the May 1985 Area Resources file, maintained by the Health Resources and Services Administration, U.S. Department of Health and Human Services.
 31. The specialty of internal medicine was used because nearly 20 percent of Medicare payments are to physicians in this one group. An average payment across all office visits for established patients was used, rather than the payment for a specific office visit code (such as a "limited office visit"), because of possible variation across regions in how the office visit codes are used.

TABLE 13. COMPARISON OF PHYSICIANS' FEES AND COSTS, BY CENSUS DIVISION AND URBAN/RURAL LOCATION, 1984

| Census Division | Internists' Average Fees for All Office Visits | | | Fees Relative to PPS Wage Index | | |
|--------------------|---------------------------------------------------|-------|-----|------------------------------------|-------|------|
| | Urban | Rural | All | Urban | Rural | All |
| New England | 25 | 16 | 25 | 0.97 | 0.75 | 0.98 |
| Mid-Atlantic | 23 | 21 | 22 | 0.82 | 0.94 | 0.79 |
| East North Central | 24 | 19 | 23 | 0.92 | 0.86 | 0.88 |
| West North Central | 24 | 12 | 19 | 0.98 | 0.58 | 0.79 |
| South Atlantic | 28 | 32 | 28 | 1.20 | 1.53 | 1.21 |
| East South Central | 20 | 18 | 19 | 0.92 | 0.93 | 0.89 |
| West South Central | 19 | 15 | 18 | 0.82 | 0.73 | 0.78 |
| Western Mountain | 27 | 22 | 27 | 1.05 | 0.98 | 1.07 |
| Pacific | 33 | 31 | 33 | 1.07 | 1.22 | 1.08 |
| Overall | 27 | 18 | 26 | 1.03 | 0.84 | 1.00 |

SOURCE: Congressional Budget Office tabulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file for fees. Cost index uses the wage index of the prospective payment system (PPS), aggregated over counties in each geographic area and using number of physicians as a weight.

variation in the 80 percent of physicians' costs that reflect earnings--either the physician's own net income or costs for nonphysician office personnel. It would only be coincidence, however, if the PPS wage index adequately reflected differences by location in the other components of physicians' costs, such as rent, office equipment and supplies, and malpractice insurance.

The actual difference in the costs of maintaining a practice may be smaller than would be indicated by any index of per unit costs, though, because of differences between urban and rural areas in the practice options available to physicians. Despite lower hourly wage rates and rental costs per square foot, rural practices may be nearly as costly to maintain as urban practices. One reason for this is that rural practices may be less able to use office personnel and space as efficiently as urban practices can, because there is less opportunity for group practice in rural areas. Another reason is that rural practices may need to maintain more fully equipped offices, because independent facilities for such things as diagnostic testing and out-patient surgery are lacking in some rural communities.

If fee differences by location do not accurately reflect differences in costs, then the structure of fees could affect physicians' decisions on where to locate. For example, because Medicare's rates are higher in urban areas than in rural areas by more than appears necessary to account for cost differences, Medicare's payment rates may have contributed to the widely cited undersupply of physicians in rural areas compared with urban areas. Despite current fee differentials, there is evidence that physicians are beginning to disperse to relatively underserved areas, in response to increasing competition for patients.^{32/} Reducing fee differentials between urban and rural areas could help to increase the rate of dispersion. In fact, some people have argued for elimination of urban/rural fee differentials, partly because practice costs do not appear to differ substantially between urban and rural areas.^{33/} In addition, analysts have suggested that the greater personal and professional amenities available in urban areas are sufficient attraction for most physicians without the need for higher payment rates to draw them.

Other Problems

As mentioned earlier, the CPR system is complex to administer and confusing for both physicians and their patients. Carriers must maintain data files on actual charges for every service provided by every physician treating Medicare patients in their jurisdictions. Approved charges are determined individually for each physician making a claim, based on the physician's customary fee and the prevailing fee in the community for that service in the previous year. Consequently, there is no uniformity in amounts paid by Medicare for a given service even among physicians in the same specialty and locality, unless they are all at the limit set by the prevailing fee. As a result, patients seeing different physicians may be liable for differing amounts for the same service, even when their physicians charge the same amounts.

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32. Projections by the Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services. See also J.P. Newhouse and others, "Where Have All the Doctors Gone?" *Journal of the American Medical Association*, vol. 247, no. 17 (May 7, 1982), pp. 2392-2396.
 33. See testimony by Kevin M. Fickenscher, Director, Office of Rural Health, University of North Dakota School of Medicine, presented at a hearing before the Subcommittee on Health, Senate Finance Committee, December 6, 1985. See also published results from the Socioeconomic Monitoring System surveys conducted quarterly by the American Medical Association.

Further, at the time of service, in many cases neither physicians nor patients know what amount Medicare will approve. As a result, patients may not know what their out-of-pocket liability will be even if their physicians accept assignment, since patients are liable for 20 percent of an unknown amount. When physicians refuse assignment, the patient's uncertainty is even greater, because liability is then 20 percent of an unknown portion of the charge plus all of that portion of the charge that exceeds Medicare's approved rate.

CHAPTER III

PROPOSALS FOR CHANGING THE CURRENT REIMBURSEMENT SYSTEM

There is widespread dissatisfaction with the customary, prevailing, and reasonable (CPR) system, and increasing awareness that, with better incentives for physicians, Medicare enrollees' access to good health care might be maintained at lower cost, both to enrollees and to Medicare. There is less agreement, however, about what changes to make in Medicare's payment methods.

This chapter reviews basic approaches by which Medicare could pay for physicians' services and discusses the Administration's plans to retain but refine the CPR system for the near term, while developing fundamental reforms for the long run. Alternative methods of payment that could replace the CPR system are described in detail in Chapters IV through VI.

BASIC APPROACHES

The basic approaches that Medicare could use to pay for physicians' services are defined by the unit of payment:

- o Per service provided (fee-for-service);
- o Per case or condition treated (case-based);
- o Per person treated for all medical needs during a specified period of time (capitation); or
- o Per period of time at work (salary).

The salary approach is not discussed in this study, because it is not under consideration as a policy option at this time. Paying physicians by salary for services to Medicare enrollees would transform Medicare from a publicly funded insurance program into a public health service for the aged and dis-

abled, with physicians who treat Medicare enrollees serving as employees of the federal government. ^{1/}

Fee-for-service payment systems--modifications of the CPR system and fee schedules--are emphasized in this study, for two reasons. First, any payment system that retained the service as the unit of payment would be a less radical change than one that substantially altered the unit of payment, so that it would be less disruptive and could be more quickly implemented. Second, service-based payment rates would likely be required even under other approaches--either as the foundation for more comprehensive payment rates, or as a residual payment system for services or population groups not covered by case-based or capitated systems.

As discussed in Chapter II, the CPR system is a fee-for-service payment mechanism that is evolving toward a set of location- and specialty-specific fee schedules anyway, as an increasing proportion of claims bump against the payment ceilings set by MEI-adjusted prevailing fees. The growing importance of the Medicare Economic Index, rather than physicians' charges, in determining annual increases in payment rates means that the incentives for fee inflation inherent in the CPR system are being weakened, but only very slowly. Further, the other problems with the CPR system discussed in Chapter II will remain, including incentives for a high volume of services, and fee differentials by service, specialty, and location that many analysts believe to be inappropriate. An additional problem is that the fee schedules that will evolve under the CPR system will reflect the structure of physicians' charges in calendar year 1971, since MEI-adjusted prevailing fees simply inflate Medicare's prevailing fees for 1973 (which were based on actual charges in 1971) by the increase in the index since that time. There have been substantial changes since then in medical technology, in the supply of physicians, and in the distribution of the Medicare population, however, that have probably altered appropriate fee differentials.

Hence, if the Congress chooses to implement a Medicare fee schedule, it might prefer one that would reflect current circumstances, rather than accepting the schedules that will evolve under the CPR system. A schedule

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1. Many physicians work for salary, either as employees of the federal government (the Public Health Service and the Veterans Administration), as hospital employees, or as employees of group practices. Except for the small share of payments made to risk-based health maintenance organizations and other prepaid medical plans, however, Medicare pays for almost all other physicians' services provided to Medicare enrollees on a fee-for-service basis regardless of how physicians are paid by the organizations where they are employed. One exception is for routine kidney dialysis, which is paid for by a monthly capitation rate.

could be developed that would ignore Medicare's current payment structure where current rates were thought to be inappropriate. Payment for services could be set below current rates in instances where there was evidence that rates were far in excess of costs, for example. Differentials in payment rates between specialties and across localities could be reduced where appropriate, and be set to reflect cost differences more accurately.

A fee schedule would not in itself, however, reduce current incentives for providing a high volume of services. Because it would still be a fee-for-service method, physicians' financial incentives would be to encourage patients to obtain all services with any potential net benefit to them. There would be no financial incentives inherent in the payment method to induce cost-conscious care by physicians. Consequently, external controls--both on individual physicians and on aggregate spending for physicians' services--would likely be necessary to limit growth in the volume of services. Such controls have been used with success in other countries in conjunction with fee schedule payment systems (see Chapter IV and Appendix A).

Alternatively, incentives to limit volume could be created as an inherent part of the payment system by basing payment on comprehensive packages of services, but such packages also carry with them the risk of inadequate care for patients. Within a package, physicians would have incentives to eliminate services with few benefits because this would reduce costs, thereby increasing profits on the package. On the other hand, because it is not always clear what services are required, some physicians might err by eliminating medically necessary services as well, with adverse consequences for patients.

Some packaging of services could be accomplished even in a service-based payment system, by combining payment for visits and tests related to some therapeutic procedures with Medicare's reimbursement for the procedure. But packaging in a case-based system would typically be more comprehensive than could be obtained under a service-based payment system, because more than one major procedure might be included in the package. Case-based payment packages, though, would probably have to be limited to inpatient episodes, where the admission would define the case or episode of care. Therapeutic procedure packages could be defined whether the procedures were performed on an inpatient or an ambulatory basis. In either instance, incentives would exist to shift services outside the package, where possible, to increase total reimbursement.

A capitated payment for all covered services would be the most comprehensive package, with no possibility for out-of-package billing. Organizations receiving payment on a capitated basis would have incentives to

minimize all forms of care within the limits of acceptable medical practice. Such organizations would serve as insurers who would either provide health care to Medicare enrollees directly or pay for services provided by others.

Some analysts view capitation as the ultimate solution to the problem of rapidly escalating health care costs, because it would create the most desirable set of incentives for the insuring organizations--so long as there was effective competition to ensure that those who provided inadequate services were eliminated. Without effective competition, enrollees' access to good health care could be seriously eroded. Even with competition, enrollees could be adversely affected during the period before they were able to change insurers. Further, in most capitation systems, an enrollee's choice of providers would likely be restricted.

THE ADMINISTRATION'S PROPOSALS

The Administration has expressed a clear preference for expanding the number of enrollees in capitated payment systems in the long run, while making refinements to alleviate the worst problems in the CPR system in the short term.^{2/} It opposes both Medicare fee schedules and expansion of the prospective payment system to include physicians' services (a case-based approach), partly on the grounds that these approaches would be "inherently regulatory." Further, the Administration contends that fee schedules would provide no significant improvement over the CPR system, and that serious (and perhaps unresolvable) implementation issues would surround expansion of the prospective payment system to include all physicians' inpatient services. Meaningful reform, the Administration maintains, can be achieved only by increasing consumer choice, competition, and capitation.

The refinements to the CPR system proposed by the Administration would be accomplished by regulation. They include the following:

- o A technical adjustment to the MEI would be made, by substituting a rental equivalence measure for the homeownership component

2. Discussion of the Administration's proposals is based on testimony given by Henry Desmarais, Acting Deputy Administrator, Health Care Financing Administration, before the Subcommittee on Health, Senate Finance Committee, December 6, 1985, and on the Administration's 1987 budget submissions. The Administration's proposal to limit the price and the frequency of replacement for prosthetic lenses following cataract surgery is not discussed, because it has already been enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985.