

TABLE B-8. STATEWIDE PARTIAL FEE SCHEDULES, PROCEDURES ONLY, BUDGET-NEUTRAL BY STATE

Physician Practices by Specialty and Location	Percent Change In				Percent of Practices for Which Medicare Allowed Amounts Would		
	Medicare Allowed Amounts	Revenue from Medicare Patients	Revenue from All Patients	Liabilities Per Service	Increase by 10 Percent or More	Change by Less Than 10 Percent	Fall by 10 Percent or More
<b>CPR Rates for Visits and Consultations; Fee Schedule for Procedures</b>							
All Practices <u>a/</u>	0.0	-0.3	-0.1	-0.9	11.3	82.4	6.3
Generalists							
General practice	1.2	0.1	0.0	-0.4	9.2	88.2	2.6
Family practice	1.6	0.4	0.1	-1.7	8.9	88.5	2.6
Internal medicine	1.0	0.2	0.1	-1.2	8.3	88.4	3.3
Specialists							
Nonsurgical <u>b/</u>	3.3	2.5	0.7	-0.1	20.0	74.4	5.6
Surgical <u>c/</u>	-2.1	-1.6	-0.5	-0.9	11.6	77.6	10.7
All Practices by Location							
Nonmetropolitan	1.1	0.2	0.1	2.1	14.8	80.6	4.6
Metropolitan	-0.2	-0.4	-0.1	-1.3	10.7	82.7	6.6

SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

- a. Includes claims submitted for the 258 top-ranked services (based on total allowed amounts) for all physicians in the sample except pediatricians, psychiatrists, osteopaths, radiologists, anesthesiologists, and pathologists. Data from 15 of the 56 Medicare carriers were excluded because of various reporting problems. The excluded carriers were for Georgia, Iowa, Michigan, eastern Missouri, Montana, New Jersey, eastern New York (the New York City area), North and South Carolina, North and South Dakota, Texas, Utah, Puerto Rico, and the Virgin Islands.
- b. Includes allergy, cardiology, dermatology, gastroenterology, nephrology, neurology, physical medicine, and pulmonary disease.
- c. Includes general surgery, otolaryngology, neurosurgery, gynecology, ophthalmology, orthopedic surgery, plastic surgery, colon and rectal surgery, thoracic surgery, and urology.

Adjusting payment rates by state would probably be appropriate, because taxes, licensing and insurance regulations, and legal systems--all with potential effects on physicians' costs--vary by state. Setting payment rates separately for metropolitan and nonmetropolitan areas within each state might also be desirable, although the need for this further refinement is less clear, as discussed in Chapter II. The results presented in this section indicate that there would be little reason to vary payment rates for all of the pay localities currently recognized by carriers. Payments would be substantially the same if there were only two types of localities in each state--metropolitan and nonmetropolitan.

A variety of choices for setting location-specific monetary multipliers are examined. The location alternatives examined here use monetary multipliers that would:

- o Not vary--a nationwide fee schedule;
- o Vary by state--either to be budget-neutral for each state or based on costs;
- o Vary by state and between metropolitan and nonmetropolitan areas within each state--either to be budget-neutral for each area or based on costs; and
- o Vary by each of the pay localities currently recognized by Medicare carriers--either to be budget-neutral for each locality or based on costs.

For the variants that were budget-neutral by location, multipliers were set so that Medicare's aggregate payments by location would be no different under the fee schedule than under the current system. Cost-based multipliers were designed to reflect cost differences by location (as measured by the PPS wage index), so that Medicare's aggregate payments by location might change (although aggregate payments nationwide would not).<sup>12/</sup> As discussed in Chapter IV, the PPS wage index may adequately account for differences in physicians' costs by location for the nearly 80 percent of costs that reflect earnings, but it probably does not account well for differences in the other 20 percent of costs--for office space, supplies, and malpractice insurance. Further, it may overstate urban/rural differences in costs for physicians.

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12. A physician-weighted average of the PPS wage index for each county was calculated statewide, separately for metropolitan and nonmetropolitan counties in each state, and separately for each pay locality.

Summary results are presented for each of the specialty alternatives examined in the previous section. The results are for all physician specialty groups combined, both for all practices nationwide and separately for practices in metropolitan and nonmetropolitan areas. The pattern of effects from alternative location-specific multipliers is similar for the first three specialty variants, and discussion therefore focuses on only the first option--with no specialty differentials (see Tables B-9, B-10, and B-11). Effects by location for the fourth specialty option--a partial fee schedule, for procedures only--sometimes differ from the effects for the first three variants (see Table B-12). These differences are discussed where appropriate.

By design, the average effect nationwide on allowed amounts would be zero for every alternative. The effects on revenues from Medicare patients and from all patients would not necessarily be zero, but they would be very small for all alternatives, on average nationwide. In no instance would average receipts nationwide change by as much as 1 percent.

The effects on practices located either in metropolitan or nonmetropolitan areas are larger, though. In general, revenues for practices in nonmetropolitan areas would increase, while they would decrease for practices in metropolitan areas. The average gains for nonmetropolitan practices would generally be substantial, while losses for practices in metropolitan areas would be quite small, because there are so many more metropolitan than nonmetropolitan practices.

Nonmetropolitan gains and metropolitan losses would be bigger as larger geographic areas were incorporated for payment purposes. For example, allowed amounts for nonmetropolitan practices would increase by 23 percent, on average, under a nationwide fee schedule with no specialty differentials (see Table B-9). If fees were set by state, instead, allowed amounts for nonmetropolitan practices would increase by between 9 percent and 15 percent. If fees were set separately for areas within each state, either by metropolitan status or using the pay localities currently defined by carriers, allowed amounts for nonmetropolitan practices would increase by only 3 percent or 4 percent, at most.

In general, nonmetropolitan areas would fare better under the alternatives that used cost-based multipliers than under those that used location-specific, budget-neutral multipliers. This is because urban/rural differentials in Medicare's current payment rates are typically larger than would be justified on the basis of costs (at least as measured by the PPS wage index). The disparity between payment rates and costs exists primarily for visits and not for procedures, though. Consequently, nonmetropolitan areas would fare less well with cost-based than with location-specific, budget-neutral multipliers under a partial fee schedule for procedures only (see Table B-12).

TABLE B-9. ALTERNATIVE LOCATION-SPECIFIC MULTIPLIERS, FOR A FEE SCHEDULE WITH NO SPECIALTY DIFFERENTIALS

Physician Practices by Location	Percent Change In				Percent of Practices for Which Medicare Allowed Amounts Would		
	Medicare Allowed Amounts	Revenue from Medicare Patients	Revenue from All Patients	Patients' Liabilities Per Service	Increase by 10 Percent or More	Change by Less Than 10 Percent	Fall by 10 Percent or More
<b>Nationwide, Budget-Neutral</b>							
All Practices <sup>a/</sup>	0.0	0.5	0.2	1.3	38.1	31.6	30.3
Nonmetropolitan	22.7	11.7	4.1	-2.9	61.1	28.6	10.2
Metropolitan	-3.3	-1.2	-0.4	1.9	34.2	32.1	33.7
<b>By State, Budget-Neutral</b>							
All Practices <sup>a/</sup>	0.0	0.0	0.0	-0.1	33.7	41.6	24.7
Nonmetropolitan	9.2	5.1	1.8	0.4	46.6	36.0	17.3
Metropolitan	-1.3	-0.8	-0.3	-0.2	31.5	42.6	25.9
<b>By State and Urban/Rural, Budget-Neutral</b>							
All Practices <sup>a/</sup>	0.0	0.1	0.0	0.1	32.2	43.3	24.5
Nonmetropolitan	0.0	1.1	0.4	1.5	40.6	43.1	16.3
Metropolitan	0.0	-0.1	0.0	-0.1	30.7	43.4	25.9
<b>By Carriers' Current Pay Localities, Budget-Neutral</b>							
All Practices <sup>a/</sup>	0.0	0.4	0.1	1.2	29.4	46.9	23.8
Nonmetropolitan	0.0	1.0	0.3	2.2	39.9	41.7	18.4
Metropolitan	0.0	0.3	0.1	1.0	27.6	47.8	24.7
<b>By State, Based on Cost Index <sup>b/</sup></b>							
All Practices <sup>a/</sup>	0.0	0.2	0.1	0.7	35.1	36.4	28.5
Nonmetropolitan	15.4	7.9	2.8	-1.6	47.3	34.6	18.0
Metropolitan	-2.2	-0.9	-0.3	1.0	33.0	36.7	30.3
<b>By State and Urban/Rural, Based on Cost Index <sup>b/</sup></b>							
All Practices	0.0	0.3	0.1	0.9	35.4	38.9	25.7
Nonmetropolitan	2.8	2.8	1.0	2.2	46.6	36.0	17.3
Metropolitan	-0.4	-0.1	0.0	0.7	33.5	39.4	27.1
<b>By Carriers' Current Pay Localities, Based on Cost Index <sup>b/</sup></b>							
All Practices <sup>a/</sup>	0.0	0.3	0.1	0.9	35.5	38.0	26.5
Nonmetropolitan	4.0	3.2	1.1	2.6	45.9	37.1	17.0
Metropolitan	-0.6	-0.1	0.0	0.7	33.7	38.2	28.2

SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

- a. Includes claims submitted for the 258 top-ranked services (based on total allowed amounts) for all physicians in the sample except pediatricians, psychiatrists, osteopaths, radiologists, anesthesiologists, and pathologists. Data from 15 of the 56 Medicare carriers were excluded because of various reporting problems. The excluded carriers were for Georgia, Iowa, Michigan, eastern Missouri, Montana, New Jersey, eastern New York (the New York City area), North and South Carolina, North and South Dakota, Texas, Utah, Puerto Rico, and the Virgin Islands.
- b. Using the prospective payment system (PPS) hospital wage index.

TABLE B-10. ALTERNATIVE LOCATION-SPECIFIC MULTIPLIERS, FOR A FEE SCHEDULE WITH SPECIALTY-SPECIFIC RELATIVE VALUE SCALES

Physician Practices by Location	Medicare Allowed Amounts	Percent Change In			Percent of Practices for Which Medicare Allowed Amounts Would		
		Revenue from Medicare Patients	Revenue from All Patients	Patients' Liabilities Per Service	Increase by 10 Percent or More	Change by Less Than 10 Percent	Fall by 10 Percent or More
<b>Nationwide, Budget-Neutral</b>							
All Practices a/	0.0	0.3	0.1	0.6	36.6	32.7	30.7
Nonmetropolitan	19.7	9.9	3.5	-1.5	58.7	29.0	12.4
Metropolitan	-2.8	-1.1	-0.4	0.9	32.9	33.3	33.8
<b>By State, Budget-Neutral</b>							
All Practices a/	0.0	-0.2	-0.1	-0.8	30.2	43.8	26.0
Nonmetropolitan	7.3	4.0	1.4	1.6	36.7	44.9	18.4
Metropolitan	-1.1	-0.8	-0.3	-1.1	29.1	43.6	27.3
<b>By State and Urban/Rural, Budget-Neutral</b>							
All Practices a/	0.0	-0.1	0.0	-0.5	29.4	45.0	25.6
Nonmetropolitan	0.0	0.9	0.3	2.3	33.2	48.4	18.4
Metropolitan	0.0	-0.2	-0.1	-0.9	28.8	44.4	26.8
<b>By Carriers' Current Pay Localities, Budget-Neutral</b>							
All Practices a/	0.0	0.3	0.1	0.5	26.9	48.5	24.5
Nonmetropolitan	0.0	0.8	0.3	2.6	33.2	46.6	20.1
Metropolitan	0.0	0.2	0.1	0.1	25.9	48.8	25.3
<b>By State, Based on Cost Index b/</b>							
All Practices a/	0.0	0.1	0.0	0.0	31.8	39.4	28.8
Nonmetropolitan	12.9	6.4	2.3	-0.5	36.7	43.5	19.8
Metropolitan	-1.9	-0.8	-0.3	0.1	31.0	38.7	30.3
<b>By State and Urban/Rural, Based on Cost Index b/</b>							
All Practices a/	0.0	0.2	0.1	0.3	32.6	40.4	27.0
Nonmetropolitan	0.4	1.4	0.5	3.5	34.3	43.8	21.9
Metropolitan	-0.1	0.0	0.0	-0.2	32.3	39.8	27.9
<b>By Carriers' Current Pay Localities, Based on Cost Index b/</b>							
All Practices	0.0	0.2	0.1	0.3	33.6	37.8	28.6
Nonmetropolitan	1.5	1.8	0.6	3.9	36.7	42.4	20.8
Metropolitan	-0.2	0.0	0.0	-0.2	33.0	37.0	30.0

SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

- a. Includes claims submitted for the 258 top-ranked services (based on total allowed amounts) for all physicians in the sample except pediatricians, psychiatrists, osteopaths, radiologists, anesthesiologists, and pathologists. Data from 15 of the 56 Medicare carriers were excluded because of various reporting problems. The excluded carriers were for Georgia, Iowa, Michigan, eastern Missouri, Montana, New Jersey, eastern New York (the New York City area), North and South Carolina, North and South Dakota, Texas, Utah, Puerto Rico, and the Virgin Islands.
- b. Using the prospective payment system (PPS) hospital wage index.

TABLE B-11. ALTERNATIVE LOCATION-SPECIFIC MULTIPLIERS, FOR A FEE SCHEDULE WITH SPECIALTY-SPECIFIC MULTIPLIERS

Physician Practices by Location	Percent Change In				Percent of Practices for Which Medicare Allowed Amounts Would		
	Medicare Allowed Amounts	Revenue from Medicare Patients	Revenue from All Patients	Liabilities Per Service	Increase by 10 Percent or More	Change by Less Than 10 Percent	Fall by 10 Percent or More
		Patients'					
<b>Nationwide, Budget-Neutral</b>							
All Practices <u>a/</u>	0.0	0.7	0.2	2.0	40.3	30.3	29.4
Nonmetropolitan	22.1	11.6	4.1	-1.8	62.9	25.8	11.3
Metropolitan	-3.2	-0.9	-0.3	2.6	36.5	31.1	32.4
<b>By State, Budget-Neutral</b>							
All Practices <u>a/</u>	0.0	0.1	0.0	0.3	36.1	39.9	24.0
Nonmetropolitan	8.7	4.9	1.7	1.1	45.9	36.4	17.7
Metropolitan	-1.3	-0.6	-0.2	0.2	34.5	40.4	25.1
<b>By State and Urban/Rural, Budget-Neutral</b>							
All Practices <u>a/</u>	0.0	0.2	0.1	0.5	34.3	41.9	23.9
Nonmetropolitan	0.0	1.1	0.4	2.0	41.0	43.8	15.2
Metropolitan	0.0	0.0	0.0	0.3	33.2	41.5	25.3
<b>By Carriers' Current Pay Localities, Budget-Neutral</b>							
All Practices <u>a/</u>	0.0	0.4	0.2	1.3	31.8	45.4	22.8
Nonmetropolitan	0.0	1.0	0.4	2.5	39.2	42.8	18.0
Metropolitan	0.0	0.4	0.1	1.1	30.6	45.8	23.6
<b>By State, Based on Cost Index <u>b/</u></b>							
All Practices <u>a/</u>	0.0	0.5	0.2	1.5	36.9	36.1	27.0
Nonmetropolitan	14.8	7.8	2.8	-0.5	45.9	34.6	19.4
Metropolitan	-2.1	-0.6	-0.2	1.8	35.4	36.4	28.3
<b>By State and Urban/Rural, Based on Cost Index <u>b/</u></b>							
All Practices <u>a/</u>	0.0	0.6	0.2	1.7	37.2	37.6	25.3
Nonmetropolitan	2.3	2.7	0.9	3.3	43.5	35.7	20.8
Metropolitan	-0.3	0.3	0.1	1.5	36.1	37.9	26.0
<b>By Carriers' Current Pay Localities, Based on Cost Index <u>b/</u></b>							
All Practices <u>a/</u>	0.0	0.6	0.2	1.7	36.8	37.9	25.4
Nonmetropolitan	3.4	3.2	1.1	3.6	44.9	36.7	18.4
Metropolitan	-0.5	0.2	0.1	1.5	35.4	38.0	26.5

SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

- a. Includes claims submitted for the 258 top-ranked services (based on total allowed amounts) for all physicians in the sample except pediatricians, psychiatrists, osteopaths, radiologists, anesthesiologists, and pathologists. Data from 15 of the 56 Medicare carriers were excluded because of various reporting problems. The excluded carriers were for Georgia, Iowa, Michigan, eastern Missouri, Montana, New Jersey, eastern New York (the New York City area), North and South Carolina, North and South Dakota, Texas, Utah, Puerto Rico, and the Virgin Islands.
- b. Using the prospective payment system (PPS) hospital wage index.

TABLE B-12. ALTERNATIVE LOCATION-SPECIFIC MULTIPLIERS, FOR A PARTIAL FEE SCHEDULE, PROCEDURES ONLY

Physician Practices by Location	Medicare Allowed Amounts	Percent Change In			Percent of Practices for Which Medicare Allowed Amounts Would		
		Revenue from Medicare Patients	Revenue from All Patients	Liabilities Per Service	Increase by 10 Percent or More	Change by Less Than 10 Percent	Fall by 10 Percent or More
<b>Nationwide, Budget-Neutral</b>							
All Practices <u>a/</u>	0.0	0.1	0.0	0.3	13.8	79.1	7.1
Nonmetropolitan	4.1	1.6	0.6	1.9	21.9	76.7	1.4
Metropolitan	-0.6	-0.1	0.0	0.1	12.4	79.6	8.0
<b>By State, Budget-Neutral</b>							
All Practices <u>a/</u>	0.0	-0.3	-0.1	-0.9	11.3	82.4	6.3
Nonmetropolitan	1.1	0.2	0.1	2.1	14.8	80.6	4.6
Metropolitan	-0.2	-0.4	-0.1	-1.3	10.7	82.7	6.6
<b>By State and Urban/Rural, Budget-Neutral</b>							
All Practices <u>a/</u>	0.0	-0.3	-0.1	-0.8	11.0	83.4	5.6
Nonmetropolitan	0.0	0.1	0.0	2.0	14.8	82.7	2.5
Metropolitan	0.0	-0.3	-0.1	-1.2	10.4	83.5	6.2
<b>By Carriers' Current Pay Localities, Budget-Neutral</b>							
All Practices <u>a/</u>	0.0	-0.1	0.0	-0.3	10.0	84.6	5.4
Nonmetropolitan	0.0	0.0	0.0	1.7	14.8	80.9	4.2
Metropolitan	0.0	-0.1	0.0	-0.6	9.2	85.3	5.6
<b>By State, Based on Cost Index <u>b/</u></b>							
All Practices <u>a/</u>	0.0	-0.3	-0.1	-0.7	12.6	80.7	6.7
Nonmetropolitan	1.7	0.5	0.2	1.9	13.8	81.6	4.6
Metropolitan	-0.2	-0.4	-0.1	-1.1	12.4	80.5	7.1
<b>By State and Urban/Rural, Based on Cost Index <u>b/</u></b>							
All Practices <u>a/</u>	0.0	-0.2	-0.1	-0.6	13.1	80.2	6.7
Nonmetropolitan	-2.9	-1.2	-0.4	3.5	15.2	79.2	5.7
Metropolitan	0.4	-0.1	0.0	-1.2	12.7	80.4	6.9
<b>By Carriers' Current Pay Localities, Based on Cost Index <u>b/</u></b>							
All Practices <u>a/</u>	0.0	-0.1	0.0	-0.3	12.7	80.3	7.0
Nonmetropolitan	-2.7	-1.1	-0.4	3.6	14.8	79.5	5.7
Metropolitan	0.4	0.1	0.0	-0.9	12.3	80.5	7.2

SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

- a. Includes claims submitted for the 258 top-ranked services (based on total allowed amounts) for all physicians in the sample except pediatricians, psychiatrists, osteopaths, radiologists, anesthesiologists, and pathologists. Data from 15 of the 56 Medicare carriers were excluded because of various reporting problems. The excluded carriers were for Georgia, Iowa, Michigan, eastern Missouri, Montana, New Jersey, eastern New York (the New York City area), North and South Carolina, North and South Dakota, Texas, Utah, Puerto Rico, and the Virgin Islands.
- b. Using the prospective payment system (PPS) hospital wage index.

The proportion of practices for which revenues would change substantially, particularly if the change would be a loss of revenues, is one indicator of how disruptive a fee schedule would be. One striking finding in this section is seen by reading down the last column in the tables, showing the percent of practices that would lose 10 percent or more in allowed amounts as a result of the payment change considered. If a nationwide fee schedule with no specialty differentials were implemented, about 30 percent of practices would lose 10 percent or more. If payment rates were adjusted by location, the proportion of practices so affected would fall, but not by much, indicating that variation in fees is nearly as large within as across geographic areas. Even if payment rates varied for every pay locality and were set to be budget-neutral for each of them, nearly 24 percent of practices would lose 10 percent or more in allowed amounts (see Table B-9). The same results would occur for each of the other two specialty alternatives under a full fee schedule (see Tables B-10 and B-11). The proportion of practices losing 10 percent or more in allowed amounts would be much smaller under a partial fee schedule, because all the effects from this alternative are small (see Table B-12). Under any of the alternatives, the impact on practice revenues from Medicare patients and from all patients would be much smaller than the effects on allowed amounts.

## SUMMARY OF FINDINGS

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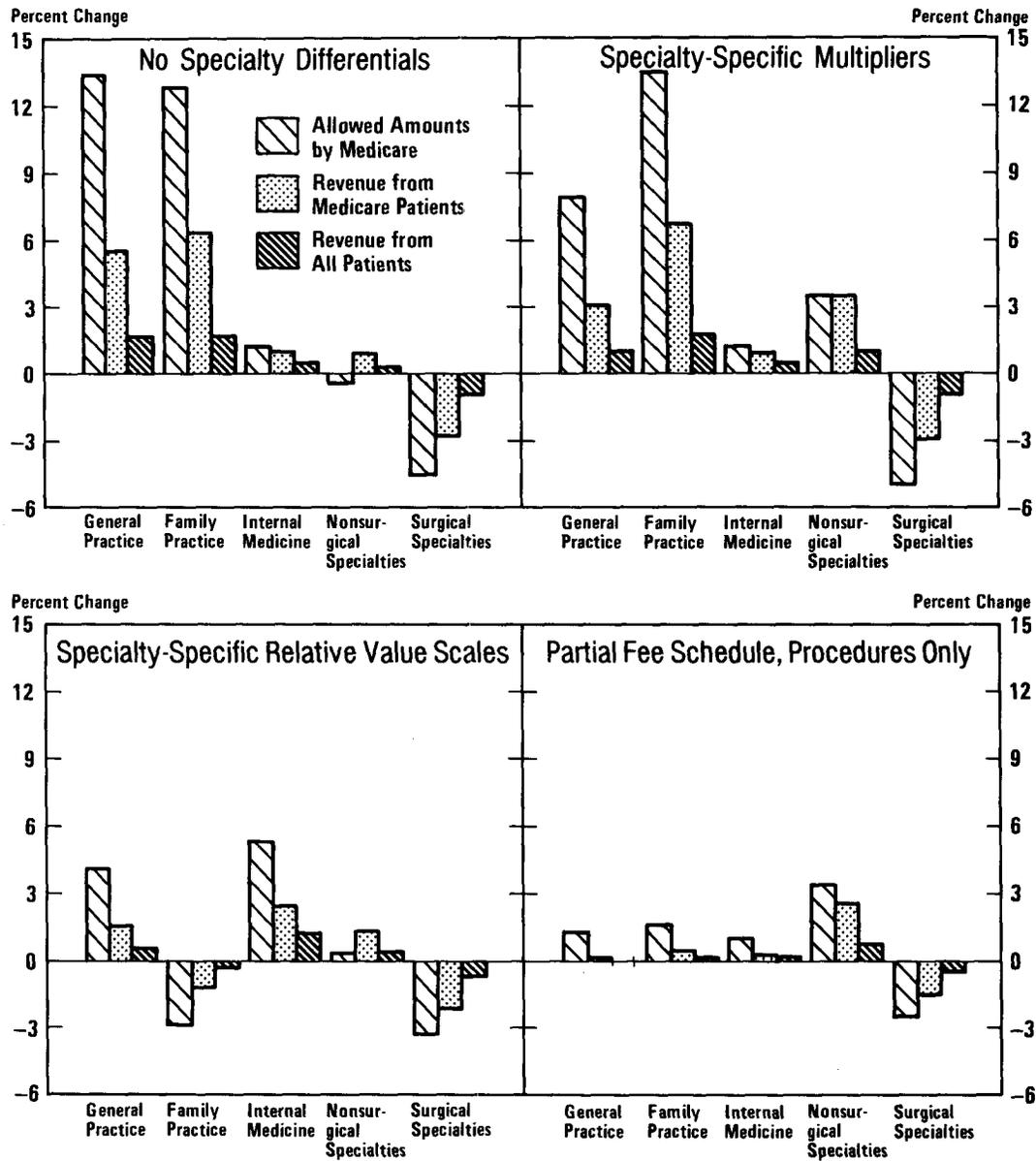
This section summarizes some of the findings for alternative fee schedules, and presents some figures that facilitate comparison of the likely impact on practice receipts. It also discusses the impact on patients' liabilities.

### Effects on Practice Receipts

Under each of the fee schedule alternatives examined here, practice receipts for generalists (as a group) and for nonsurgical specialists would increase, while receipts for surgical specialists would fall, on average nationwide. Among generalists, gains for general and family practitioners would usually be larger than for internists. The one exception to this would occur under a fee schedule with specialty-specific RVs, where internists would gain more than general practitioners and where family practitioners would lose revenues, for reasons explained earlier (see Figure B-1).

The general direction of these effects would be desirable if it were thought that surgical services were reimbursed too generously relative to payments for primary care, as is often asserted. Some of the fee schedule options examined here, however, could result in payment rates per unit of

Figure B-1.  
 Percent Change in Practice Receipts After Implementing Statewide Budget-Neutral Fee Schedules, by Physician Specialty



SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

time for general and family practitioners that were higher than rates paid to internists, because of differences among the specialty groups in the average length of visits of a given type. If visit codes were redefined to reflect time, receipts for general and family practitioners would likely increase far less under these options, while receipts for internists would increase more.

Except for the alternatives that would establish payment rates that were budget-neutral for areas within each state, the full fee schedule options examined here would increase practice receipts in nonmetropolitan areas appreciably, offset by small reductions in practice receipts in metropolitan areas. (See Figure B-2, which shows allowed amounts. The pattern would be similar for revenues from Medicare patients or from all patients, although the size of the effects would be much smaller.) These results also would be desirable if, as is widely believed, current payment rates do not adequately account for the costs of rural practice and the relative under-supply of physicians in such areas.

About one in four practices nationwide would face a drop of 10 percent or more in allowed amounts if any of the full fee schedule options examined here were implemented, so that the potential for disruption could be significant. The impact on practice revenues from Medicare patients would be substantially smaller, though, because practice revenues would not change at all for unassigned claims. Further, the impact on practice revenues from all patients would be very small, on average, because non-Medicare patients account for 80 percent of practice revenues overall. For about 20 percent of practices, however, Medicare patients account for 50 percent or more of the patient load, and implementation of a Medicare fee schedule could be quite disruptive for these practices. 13/

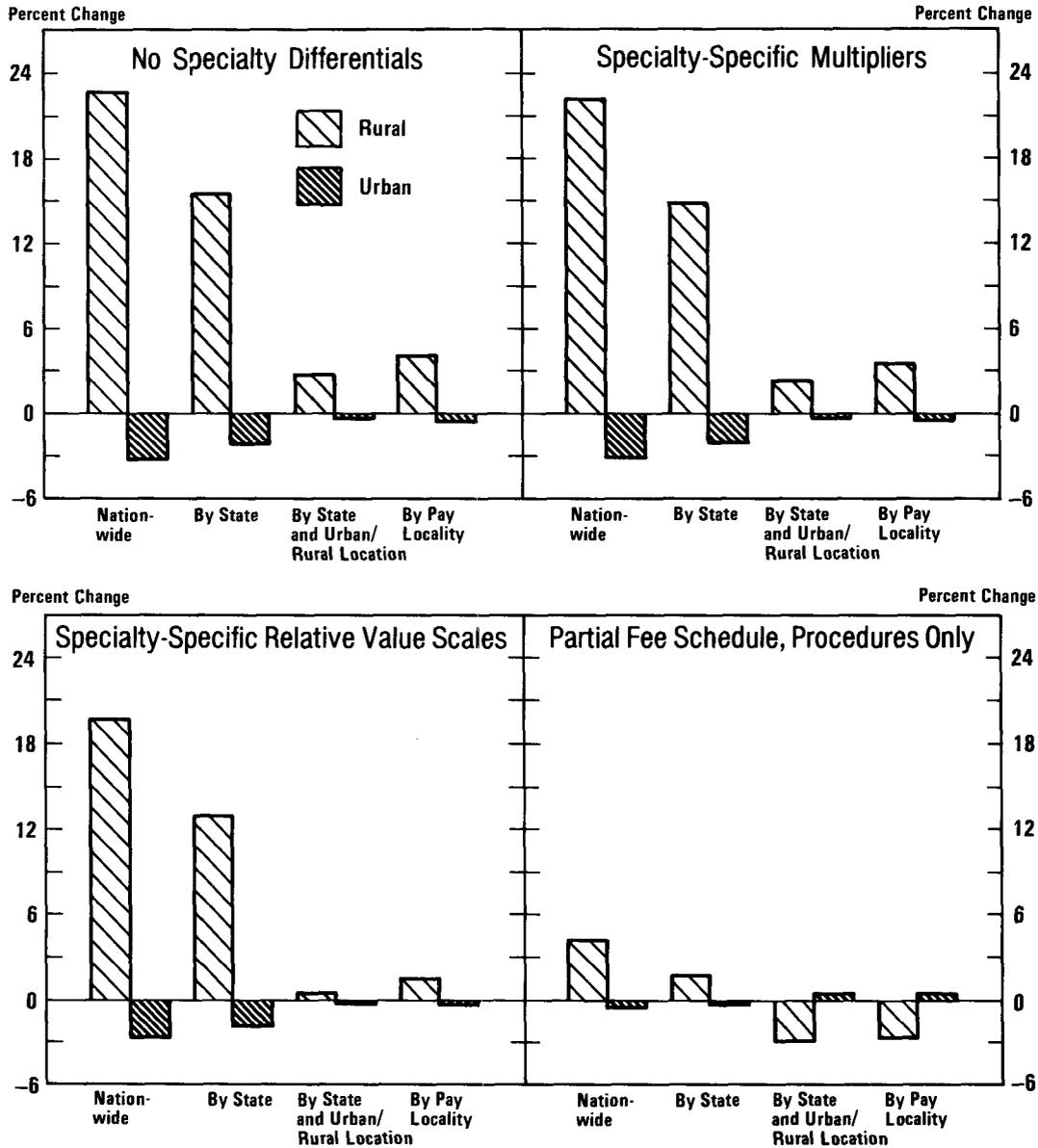
#### Effects on Patients' Liabilities

Because the data base used for the analysis is a sample of physician practices and not of Medicare enrollees, no assessment of the impact of alternative options on enrollees' total liabilities could be made. Instead, results presented show the impact on average liability per service. Patient liabilities were defined to include not only deductible and coinsurance amounts on Medicare's approved charges, but also balance-billing amounts on unassigned claims.

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13. Congressional Budget Office tabulations from HCFA's latest survey of Physicians' Practice Costs and Income, for income year 1983.

Figure B-2.  
 Percent Change in Allowed Amounts After Implementing Fee Schedules Using Location-Specific Multipliers Based on Costs, All Practices by Location



SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

The average liability per service currently is \$15; changes in this amount under the options examined here would be small. Increases in liability, which are probably of more concern than reductions, would in no instance exceed 4 percent. This is an average, however, and the impact on patients for specific services could be larger. Further, these results assume that physicians' assignment decisions would be unchanged despite a change in payment rates, and this assumption would not be valid in all cases.

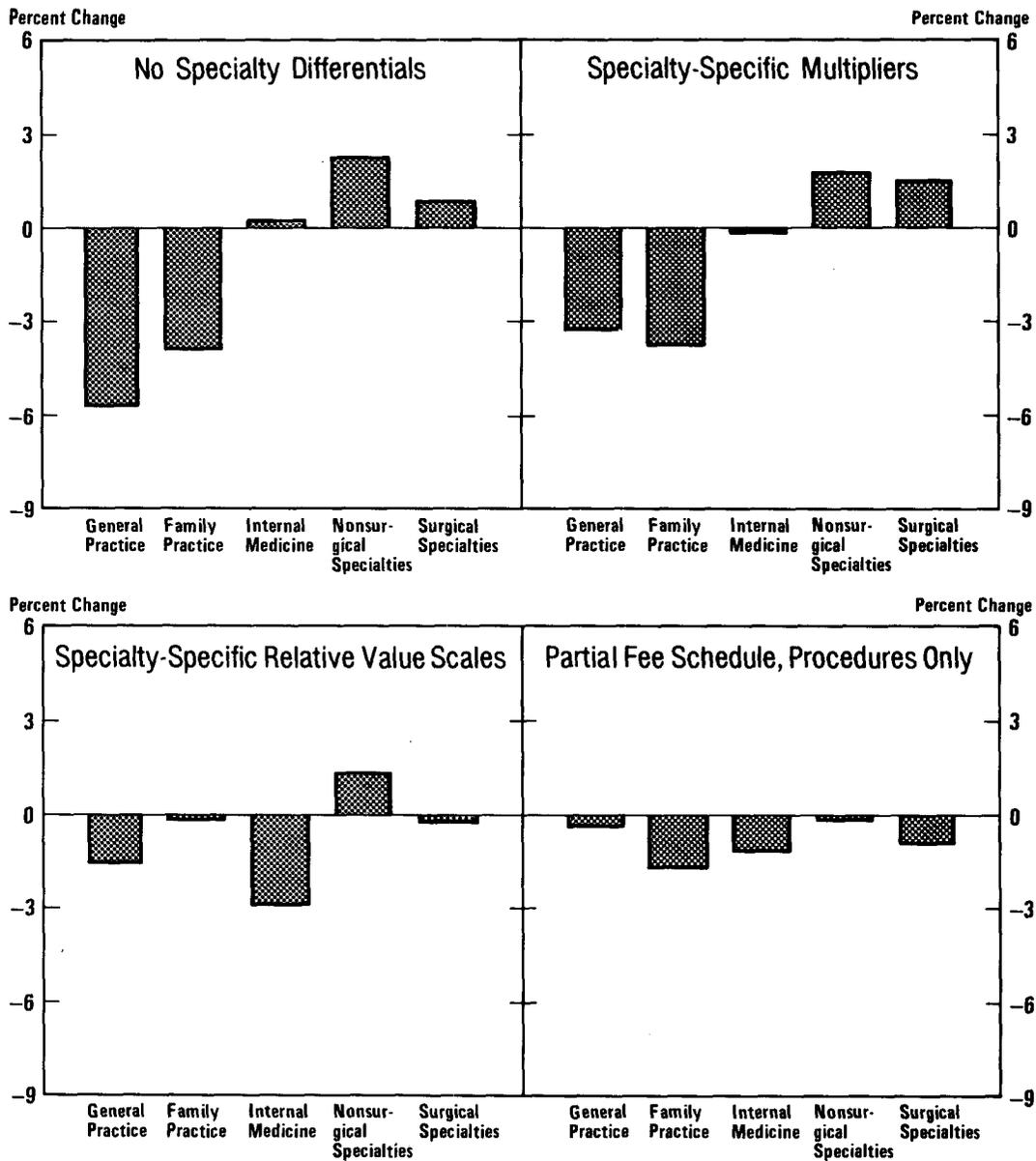
Under all the specialty alternatives examined here, patients' liabilities would be reduced for the services provided by generalists, while they would generally be increased or nearly unchanged for the services provided by nonsurgical and surgical specialists (see Figure B-3). Each of these effects would probably be larger if assignment rates changed, because the likely changes would be increased assignment by generalists (whose payment rates would increase) and reduced assignment by specialists (whose payment rates would fall).

On average nationwide, patients' liabilities would generally increase slightly regardless of the specialty variant used or the way in which location-specific multipliers were set. One exception to this would occur under a partial fee schedule, for procedures only. In this instance, patients' liabilities would fall, on average nationwide, so long as payment rates varied by state or some smaller geographic area.

The changes in patients' liabilities would typically be smaller for alternatives that would set budget-neutral multipliers by location (Figure B-4), compared with alternatives that would set location-specific multipliers based on costs (Figure B-5). For the budget-neutral alternatives, patients' liabilities would in no case increase by more than 3 percent. For the cost-based alternatives, increases of nearly 4 percent would occur in some instances.

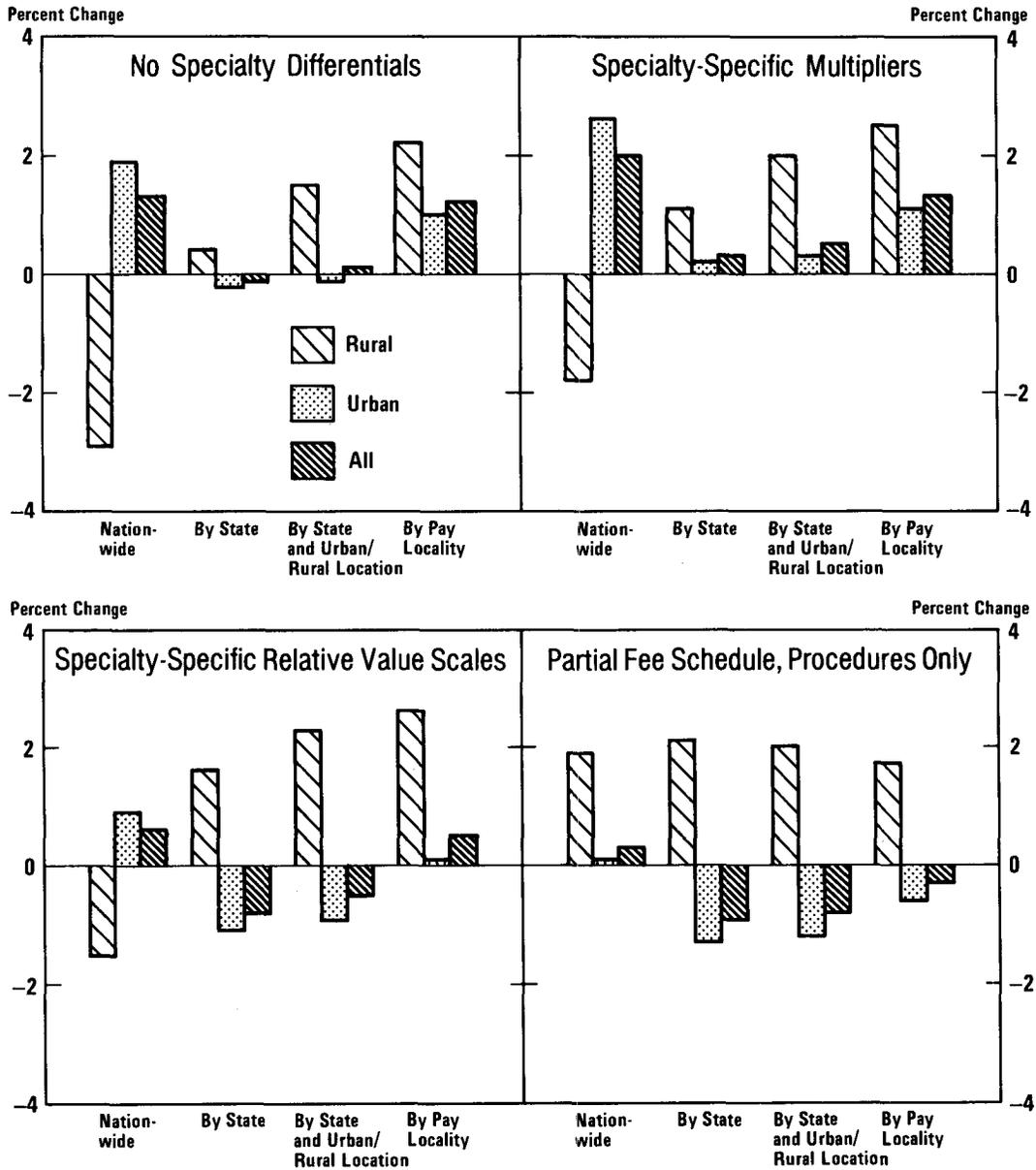
Another difference between alternatives using location-specific, budget-neutral multipliers and those using cost-based multipliers would occur for statewide (full) fee schedules. Using budget-neutral multipliers to set statewide payment rates, patients' liabilities in nonmetropolitan areas would increase under each specialty variant. If cost-based multipliers were used instead, patients' liabilities would fall in nonmetropolitan areas. These effects would occur because physicians' payment rates in nonmetropolitan areas would increase by more under cost-based statewide fee schedules than under fee schedules that were budget-neutral by state. Assignment rates are relatively low in nonmetropolitan areas, and higher payment rates in such areas would reduce patients' liabilities by reducing the balance-billing amounts they would have to pay.

Figure B-3.  
 Percent Change in Patients' Liabilities Per Service After Implementing  
 Statewide Budget-Neutral Fee Schedules, by Physician Specialty



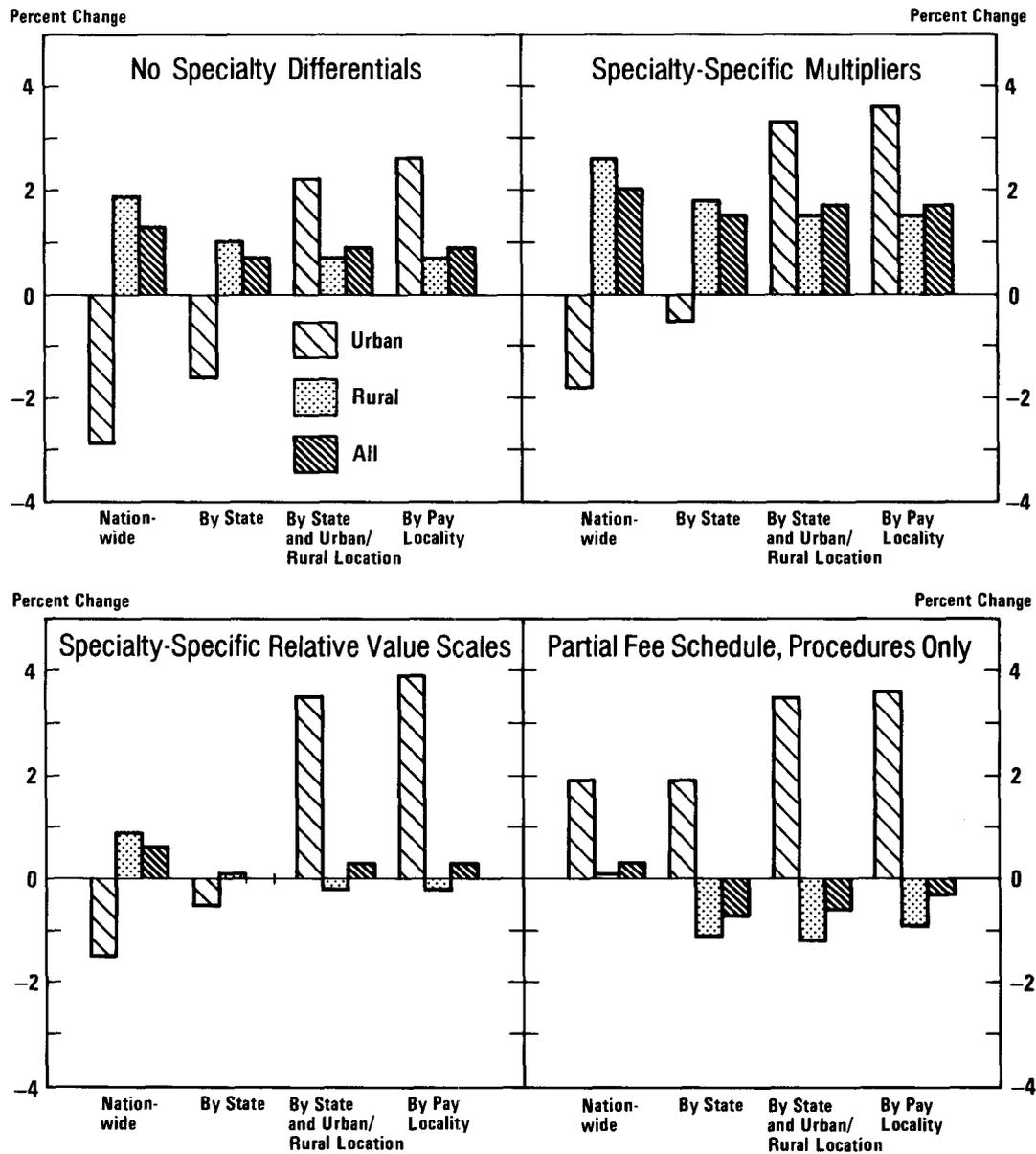
SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

Figure B-4.  
 Percent Change in Patients' Liabilities Per Service After Implementing Fee Schedules Using Budget-Neutral Multipliers, by Location



SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

Figure B-5.  
 Percent Change in Patients' Liabilities Per Service After Implementing Fee Schedules Using Multipliers Based on Costs, by Location



SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.