

Brief Report

The Health Care Financing Administration conducts research, demonstration, and evaluation projects under legislative authorities included in the Social Security Act, the Public Health Service Act, and the Rural Health Service Act.

When the Congress feels that additional information is necessary to make legislative changes to a specific area of the Medicare and Medicaid programs, it directs HCFA to conduct a study, demonstration, or evaluation project to answer this need.

To ensure that the health community is aware of the results of these Congressionally mandated studies, the *Health Care Financing Review* will include, from time to time, a summary of the findings that have been officially transmitted to the Congress. This summary reports on the findings of a study mandated by P.L. 96-499, the Omnibus Reconciliation Act of 1980, Section 958(b).

Medicare Second Surgical Opinion Programs: The Effect of Waiving Cost-Sharing

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This report was prepared pursuant to Section 958(b) of the Omnibus Reconciliation Act of 1980, Public Law 96-499, which examines the desirability of waiving present Medicare cost-sharing requirements for second surgical opinions. It is based on current results from the Department's comprehensive evaluation of second surgical opinion programs being conducted by Abt Associates, Inc., and on additional analyses conducted by the author.¹

The findings presented in this report indicate that waiving cost-sharing as an incentive for Medicare beneficiaries to voluntarily obtain second opinions does not appear to result in extensive use of the benefit. Voluntary second opinion program users are a select group of beneficiaries actively seeking health care information. These beneficiaries decided that unquestioned compliance with surgical recommendations may not be in their best interest. As measured by the demonstrations, relatively few Medicare beneficiaries currently seek second opinions.

¹For a detailed description of evaluation findings, see Poggio *et al.*, 1981. Eugene Poggio, Ph.D., is the project director. In addition to the Medicare SSOP demonstrations, this contract also included an evaluation of the Massachusetts Consultation Program for Elective Surgery, a State-administered, mandatory SSOP for Medicaid recipients, and the National Second Surgical Opinion Program, a DHHS/HCFA-administered second opinion public information and referral program. The evaluation also includes a review of the literature on SSOPs and a survey of private sector SSOPs.

There has been considerable interest in the past five years regarding the appropriate use of surgical services. The Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce published a report entitled "Cost and Quality of Health Care: Unnecessary Surgery" in January 1976. The report observed the following:

- Unnecessary surgery wastes lives and dollars. The Committee estimated that 2.4 million unnecessary surgeries were performed in 1974 at a cost to the American public of \$4 billion. These unnecessary surgeries were claimed to have led to 11,900 avoidable deaths.
- Second consultations before surgery could cut down significantly on unnecessary surgical procedures. The Department should promptly institute a program of independent second professional opinions to confirm the need for elective surgery underwritten by Medicare and Medicaid. Such a program would save the government millions of dollars.
- The second opinion program should be carefully evaluated to determine a) the impact upon quality of care, b) the containment of health care costs, c) the percentage of surgical procedures deemed unnecessary, and d) the cost of administering such a program compared with the cost of unnecessary procedures.

In May 1977, the Department of Health and Human Services, Health Care Financing Administration (HCFA), Office of Research, Demonstrations, and Statistics, initiated activities to design and implement demonstration projects to test whether a financial incentive would encourage Medicare beneficiaries to voluntarily seek a second opinion. These programs offered a second surgical opinion benefit with no out-of-pocket costs for Medicare beneficiaries. In September 1977, HCFA awarded contracts to Blue Cross and Blue Shield of Michigan and Blue Cross and Blue Shield of Greater New York. The New York Second Surgical Opinion Program (SSOP) began providing services in April 1978, and the Michigan demonstration in August 1978. Both demonstrations provided benefits for three years.

These Medicare SSOP demonstration projects are structured and voluntary. They use referral centers to facilitate patient access to the second opinion physician and to manage payment for the second opinion benefit (that is, to assure that the patient is eligible for the benefit and that billing information clearly

identifies the service as a second opinion provided by a participating consulting physician). The SSOPs establish and maintain physician consultant panels which allow them to control which physicians are qualified to provide second opinions and ensure the independence of the second opinion. (That is, the program requires that second opinion consultants agree not to perform the surgery in question on the patients seeking their second opinion.)

In New York, 1,900 board-certified surgeons distributed throughout the 17 lower New York counties were available as second opinion consultants. In Michigan, approximately 200 board-certified surgeons, osteopaths, and podiatrists were available to Medicare beneficiaries residing in the three-county Detroit standard metropolitan statistical area serviced by this demonstration.

The SSOPs conduct publicity campaigns promoting the second opinion benefit.

The Michigan and New York SSOP demonstrations differ from each other in two ways. First, the New York program defines the first opinion physician as the first surgeon to recommend surgery. The Michigan program is indifferent as to whether a surgeon or medical physician provides the first opinion. Second, in Michigan the referral center assists the patient in arranging the second opinion visit. In New York, the beneficiary schedules his or her own appointment.

In a separate activity in November 1977, HCFA sent instructions to Medicare carriers which explicitly assured coverage of patient-initiated second and third opinions under the Supplementary Medical Insurance Program, Medicare Part B. However, these Part B services are subject to an annual deductible—\$75 effective January 1, 1982—and beneficiary cost sharing equal to 20 percent of the Medicare allowable fee plus any amounts in excess of the Medicare allowable amount.

Although analyses of the long-term cost and health impacts of SSOPs are not available, the following current findings from the analysis of the Medicare SSOP demonstrations bear directly on the issue of waiving Medicare cost-sharing for second opinions (Poggio *et al.*, 1981):

- Participation rates in voluntary SSOPs are very low—around 2 to 5 percent. The Medicare demonstration SSOPs show similarly low rates, with participation ranging from 0.5 to 2 percent of those eligible beneficiaries considering surgery.
- The Medicare demonstration SSOPs at best reduced the amount of surgery among those who participated by about 12 percent. If 2 percent of Medicare beneficiaries participate in a structured, voluntary second surgical opinion program, and surgeries among these participants decline by 10 to 15 percent, then the overall reduction in total beneficiary surgery is 0.2 to 0.3 percent.

- A substantial proportion of patients who received confirming second opinions did not have surgery. More than one of every three confirmed patients did not have surgery within one year. Nonetheless, it is possible that confirmations raised the likelihood of surgery for demonstration participants. Since confirmations outnumber non-confirmations by about 2 to 1, the offset of increased surgery could exceed the reduction from non-confirmations and yield an increase in the total number of elective surgeries performed. However, the net effect could be more appropriate care and, in turn, lower long-run costs, morbidity, and mortality.

The body of this brief report addresses the following questions:

- How does cost-sharing influence Medicare beneficiaries' use of second opinions?
- Why is Medicare beneficiaries' use of voluntary SSOPs low, and what is the effect of various efforts to promote higher use?
- What level of reimbursement is necessary for Medicare SSOPs to recruit and retain second opinion consultants?
- What is the effect of second opinions on the surgical decisions of Medicare SSOP participants? Do Medicare voluntary SSOPs decrease surgery?

Use of Voluntary SSOPs in the Demonstrations

Medicare beneficiaries' use of the voluntary SSOP demonstration projects has been low (Poggio *et al.*, 1981). From May 1978 through December 1980, 4,407 second opinions were obtained through the New York demonstration, an average rate of 1,763 per year (Poggio *et al.*, 1981). In 1977, the latest year for which data are available, approximately 142,000 Medicare beneficiaries of the 1.5 million Medicare beneficiaries living in the SSOP service area had inpatient surgery performed in hospitals in the service area (HCFA, 1977). Recognizing that a certain unknown percentage of these procedures are not elective, the conservative estimate of the annual second opinion use rate is:

$$\frac{1,763 \text{ second opinions}}{142,000 \text{ surgical procedures}} = .012$$

Calculating the utilization rate in this manner only approximates the true rate, since "recommendations for surgery" is a more accurate denominator against which the number of second opinions obtained should be compared.

In Michigan, the use rate was lower (Poggio *et al.*, 1981). During the first two years of the Michigan SSOP, an average of 116 people per year obtained second opinions through the program (Poggio *et al.*, 1981). In 1977, approximately 44,000 surgeries were performed on the 420,000 Medicare beneficiaries in the Detroit area (Blue Cross and Blue Shield of Michigan, 1978). Thus, the conservative estimate of the annual second opinion use rate in the Michigan Medicare SSOP is:

$$\frac{116 \text{ second opinions}}{44,000 \text{ surgical procedures}} = .003$$

This utilization rate is about one-fourth that of the New York program.

These findings of low utilization in the voluntary Medicare SSOP demonstrations are consistent with, but are even lower than, the use of private sector voluntary SSOPs, 2 to 5 percent of the eligible insureds (Poggio *et al.*, 1981).

The following sections discuss several factors which can influence the SSOP use rate:

- the potential influence of cost-sharing
- other monetary and non-monetary costs
- beneficiary awareness and program promotion.

The Potential Influence of Cost-Sharing on Medicare Beneficiary Use

The positive effect of a second opinion—to encourage an appropriate surgical decision—can only be achieved if people use the benefit. The magnitude of cost-sharing has been repeatedly shown to be inversely related to use rates for health services (Scitovsky and Snyder, 1972; Donabedian, 1976). However, the *marginal* effect of cost-sharing on use of second opinions has not been studied. Although the hypothesis that reduced patient cost-sharing will increase beneficiary use of second opinions is plausible, the data necessary to directly answer the question of whether offering a no-cost second opinion actually increased second opinion use are not available.

The reimbursement incentive approach used in the Medicare demonstrations is based on the assumption that beneficiaries will be more inclined to voluntarily obtain a second opinion if no out-of-pocket cost is incurred. Beneficiaries obtaining second opinions outside the demonstrations incur out-of-pocket costs in the form of coinsurance (that is, the requirement that the patient pay 20 percent of the allowable charges for services and the annual Part B deductible). In addition, the beneficiary is responsible for paying any charges in excess of Medicare's allowable charge, except where the second opinion physician accepts Medicare assignment.

Second and third opinions are currently covered under the Supplementary Medical Insurance Program, Medicare Part B, and are subject to a deductible of \$75 and coinsurance of 20 percent of the physician's "usual, customary, and reasonable" charge (the Medicare allowable charge).

If the physician accepts assignment, the beneficiary is responsible for 20 percent of the physician's charges up to the Medicare allowable amount, and the Medicare carrier will pay the physician 80 percent of the fee up to the allowable charges. (For purposes of this discussion, it is assumed that the deductible has already been met.) On the other hand, if the physician does not accept assignment, the beneficiary is also responsible for paying those physician charges in excess of the Medicare allowable charges. Current data indicate that 52 percent of physician claims and charges are rendered on an assignment basis (HCFA, 1980).

A beneficiary in the New York demonstration area receiving a non-demonstration second opinion consultation on an assigned claim basis would pay up to \$14.14, based on the maximum Medicare allowable charge of \$70.70 for an extensive consultation (Blue Cross and Blue Shield of Greater New York, 1981). However, if the claim is unassigned, the average beneficiary would have to pay roughly 15 to 20 dollars more than \$14.14, since national data show that physician charges for unassigned claims exceed total covered charges by 28 percent (HCFA, 1980).²

The out-of-pocket cost to the beneficiary is reduced or eliminated if the beneficiary has supplemental insurance (a Medigap policy) covering physician office visits. In 1979, an estimated 26.5 percent of beneficiaries nationally had such insurance (Carroll and Arnett, 1981). Most policies would pay the coinsurance; some would pay part or all of the charges in excess of the Medicare allowable amount. No out-of-pocket costs are incurred by those beneficiaries covered by Medicaid, who, as of July 1, 1979, constituted 8.1 percent of Medicare beneficiaries nationally, and 9.5 percent and 6.9 percent in New York and Michigan, respectively (Beisal and Terrell, 1981; Barrett, 1981).

Thus, for the minority of beneficiaries covered by Medicaid or supplemental insurance, one effect of eliminating beneficiary copayments for second opinions would be a shifting of costs from States and insurers to Medicare, with little or no difference in the out-of-pocket cost to the beneficiary. In other words, for these segments of the beneficiary population, waiving copayment provides no added incentive to seek a second opinion.

²The maximum allowable charge will exceed the average covered charges, and thus the extra cost to the beneficiary will average less than 28 percent of the maximum allowable charge (\$19.80).

It is not possible to directly determine whether the financial incentive for the remainder of the Medicare beneficiaries in fact induced additional utilization of second opinions, since some of those who participated in the demonstration might have otherwise been willing to pay out of pocket for a second opinion.

Evaluation data now being gathered could be used to measure the marginal utilization inducement effect of waiving copayments under the demonstration for those at risk of out-of-pocket costs.

Non-Reimbursement Cost Factors Affecting Use

Among Medicare beneficiaries recommended for elective surgery, some will not desire a second opinion following a recommendation, although it is provided at no out-of-pocket cost. While the money price for a second opinion may be relatively inexpensive under regular Medicare reimbursement and was free in the demonstrations, the total cost to the patient of a second opinion may be high. Total cost includes travel costs, possible lost income, and other non-monetary costs (Pauly, 1979). In addition to the cost of an additional trip to the second opinion physician, there is waiting and travel time. More importantly, there are motivational costs associated with the possible inconvenience of locating a second opinion consultant, arranging for the transfer of records, and submitting to the examination itself. Some Medicare beneficiaries may also be unwilling to experience the uncertainty of conflicting advice which could occur if they receive a non-confirming second opinion.

These non-monetary costs may be so important that the presence or absence of coverage of relatively small monetary costs for a second opinion may not make much difference in use. A major goal of the HCFA evaluation is to identify the motivational factors influencing obtaining second opinions and thoroughly understand compliance with surgical recommendations.

Secondly, the value of the information gained from a second opinion is dependent on the patient's uncertainty about the efficacy of care or the diagnosis of his/her condition. Medicare beneficiaries who are presented with a strong and quite believable first opinion of the likely benefits of surgery, or who have a strong rapport with the first opinion physician, may not value seeking a second opinion, an act which could be interpreted as questioning physician authority (Haug and Lavin, 1979).

That Medicare beneficiaries place a relatively low value on the voluntary second opinion benefit is partially supported by reasons given for cancellations of second opinion appointments. In the SSOP demonstrations, the most frequent reason for not obtaining a second opinion once an appointment had been scheduled was the patient's decision to proceed with surgery without waiting for the second opinion. Of

316 New York Medicare beneficiaries who cancelled their requests for a second opinion, 30.7 percent (97) decided to undergo surgery or continue their present course of treatment without getting a second opinion (Blue Cross and Blue Shield of Greater New York, 1980). An additional 22.2 percent of cancellations (70) stated that they would seek a second opinion but would use a physician who was not on the consultant panel, thus foregoing the no-cost demonstration project benefit.³ The Michigan demonstration yielded similar findings (Blue Cross and Blue Shield of Michigan, 1980).

Beneficiary Awareness

The experience of the New York demonstration indicates that lack of awareness of the program is also partially responsible for low use. The importance of establishing an on-going, cost-effective publicity campaign to promote voluntary second opinions should not be under-emphasized. A mass mailing publicity campaign in New York raised program use more than two-fold from an overall use rate of 1 to 2 percent of eligible beneficiaries. However, that mass publicity persuaded only 4 percent of beneficiaries considering elective surgery to use the program strongly suggests limited attractiveness of the benefit.

During the period February to April 1980, 2 million single sheet "bill stuffers" describing the New York SSOP demonstration were enclosed with the Explanation of Medicare Benefits and Medicare bill statements. The Medicare population in the New York service area is approximately 1.5 million.

Bill stuffers were the most cost-effective method for publicizing the New York demonstration (Poggio *et al.*, 1981). Of 4,407 second opinions provided to New York Medicare beneficiaries where the source of program information is known, 26 percent (1,162) resulted from the bill stuffer. The estimated cost of using bill stuffers is \$4.50 per second opinion (Poggio *et al.*, 1981). This compares, for example, with \$320 per second opinion generated by newspaper advertisements which appeared on 10 separate occasions.

Physician Participation in Second Opinion Programs

To implement and operate a successful SSOP, it is necessary to recruit a sufficient number of physicians to ensure that beneficiaries have reasonably convenient access to consultants appropriate to their conditions. This section discusses the demonstration experience and the reimbursement and other factors which affect physician participation. The demonstration experience indicates that sufficient numbers of surgeons in most specialties were recruited.

³Beneficiaries may have obtained non-program second opinions at no cost if they had Medigap insurance policies which covered coinsurance costs for second opinions.

At the beginning of the New York demonstration, Blue Cross and Blue Shield of Greater New York's subscriber second opinion program, Program for Elective Surgical Second Opinion (PRESSO), had already recruited some 2,000 board-certified surgeons to its SSOP consultant panel from among 6,000 area surgeons who had been invited to participate. The principal reasons given for refusal to participate in the private SSOP were the following (Blue Cross and Blue Shield of Greater New York, 1978):

- The reimbursement fee was inadequate.
- The forms were time consuming to complete.
- The terms of the agreement were confining, particularly as they related to the surgeon being required not to treat the patient or perform surgery.
- The concept perhaps was not one that they wished to support.

The New York Medicare demonstration recruited 1,900 of the 2,000 physicians already participating in PRESSO. Only two subsequently withdrew from the Medicare demonstration in its first two years, citing inadequate reimbursement as the reason (Blue Cross and Blue Shield of Greater New York, 1980).

In Michigan, recruitment of consultants was also associated with Blue Cross and Blue Shield's private SSOP efforts. Approximately 21 percent of eligible surgeons participated in the Michigan SSOP demonstration (Blue Cross and Blue Shield of Michigan, 1978). In Michigan, only limited numbers of consultants were available in neurosurgery, plastic surgery, proctology, and thoracic surgery. No physicians withdrew from the Michigan SSOP on the basis of inadequate reimbursement.

The maximum allowable fee is thought to be a major factor affecting physician participation. The allowable fee must be high enough to attract a sufficient number of physicians. A fee level which attracted most or all of the potential second opinion consultants would generally be considered too high, since a lower fee would probably attract a sufficient number at a lower total cost. However, if the maximum fee is set substantially lower than the prevailing maximums for consultations, physicians in a non-structured SSOP would find it more remunerative to label second opinions as consultations. This in turn would dilute the effectiveness of the no-cost second opinion.

In the Detroit and New York Medicare demonstrations, the maximum fee of \$50 for office-based second opinions was sufficient to recruit and retain an adequate number of surgeons in most specialties to serve on consultant panels. This fee maximum, which remained in effect for the three years of the demonstration, roughly parallels the national prevailing charges for an extensive consultation. National data for 1978 indicate that 75 percent of all prevailing fees for an extensive consultation were less than or equal to \$57 (HCFA, 1980). Second opinion consultations

may not be similar in level of effort and time (O'Connor, 1981).

The \$50 second opinion fee maximum in the demonstration was about \$20 below the maximum allowable charge for an extensive consultation in New York and \$8 below the maximum for the Detroit area.⁴ If the extensive consultation is an appropriate comparison, the higher participation rate in the New York demonstration suggests that factors other than remuneration have a strong effect on physician participation rates in voluntary SSOPs.

SSOP Medicare Beneficiary Experience

To reduce health care costs and to improve quality of care and health outcomes, second surgical opinion programs must reduce the amount of inappropriate surgery performed. This section discusses the impact of the second opinion (that is, surgical confirmation or non-confirmation) on beneficiaries' surgical decisions. It further addresses the issues of whether Medicare voluntary SSOPs decrease surgery and whether these programs unduly delay surgical decisions.

Based on the experience in the New York demonstration, HCFA's best estimate is that the voluntary Medicare SSOP did not reduce the probability of surgery among participants by more than 12 percent. Findings from the demonstrations also indicate that voluntary second opinions obtained through these programs did not unduly delay beneficiaries' surgical decisions.

Non-Confirmation Rates in the Demonstrations

A non-confirmation from a second opinion consultant reflects a professional judgment different from the first physician's. A variety of reasons were given by consultants for non-confirmations, ranging from findings of no pathology to justify surgery through recommendations for alternative modes of medical or surgical treatment. Thus, a non-confirmation does not imply an absolute lack of medical necessity, but rather may indicate only that there is disagreement between two physicians as to the most appropriate course of treatment for an individual patient.

As shown in Table 1, the overall non-confirmation rates are 31.6 percent in New York and 36.4 percent in Michigan (Poggio *et al.*, 1981). In both programs, participants whose first opinion surgeons had discussed, but not recommended surgery had the need for surgery confirmed less often.

⁴In calendar year 1979, the prevailing charge for an extensive consultation was \$70.70 in New York City and \$58 in Detroit.

TABLE 1

Non-Confirmation Rates by Program and Surgery Discussed Versus Recommended Status

Second Opinion Outcome	New York		Total	Michigan		Total
	First Opinion Physician:			First Opinion Physician:		
	Recommended	Discussed		Recommended	Discussed	
Confirmed	69.9%	54.4%	68.4%	65.6%	31.3%	63.6%
Non-confirmed	30.1%	45.6%	31.6%	34.4%	68.7%	36.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sample Size	3,980	412	4,392 ¹	256	16	272

Source: Poggio *et al.*, 1981.

¹Excludes 15 cases for which discussed versus recommended status is unknown.

These results are consistent with findings in private sector voluntary SSOPs in which non-confirmation rates range from 24.8 to 33.4 percent (McCarthy *et al.*, 1980; Paris *et al.*, 1979; Joffe and Schachter, 1980). Non-confirmation rates in mandatory SSOPs are approximately 10 percentage points lower, (that is, 15 to 25 percent) (Martin *et al.*, 1980; McCarthy *et al.*, 1980). The self-selection of patients who may have greater reservations regarding the necessity of surgery has been suggested by McCarthy and Widmer (1974) as one explanation for the higher non-confirmation rates in voluntary SSOPs.

Impact of Second Opinions on Surgery Rates

While approximately 70 percent of beneficiaries in the demonstrations were confirmed for surgery and 30 percent were not, it is not possible to directly and reliably estimate the effect of a confirming or non-confirming second opinion on surgery decisions. It is assumed that persons who are not confirmed will be less likely to have surgery than they would have been had they not obtained these second opinions. Conversely, some beneficiaries receiving confirmations may be persuaded to undergo an operation that they would not have had otherwise. SSOP studies to date have not measured the extent to which non-confirmations discourage surgery and confirmations encourage surgery. To estimate what Medicare beneficiaries who sought a second opinion through the demonstrations would have done if they had not obtained these second opinions would require an analysis of the experience of Medicare beneficiaries recommended for elective surgery who did not participate in the demonstrations. Nonetheless, the data from the demonstrations are adequate to estimate the maximum possible surgical reduction.

As Table 2 shows, the difference between the non-confirmed surgery group and the confirmed surgery group is approximately 40 percentage points. Thus, the maximum effect of a non-confirming second opinion on the probability of surgery is assumed to be a

reduction of 40 percent. Since approximately 30 percent of second opinions are non-confirmations, the maximum reduction in surgery rates attributable to the effect of non-confirming second opinions is approximately 12 percent. This estimate discounts the probable off-setting effect of confirming second opinions on inducing surgery (Sieverts, 1980).

Conclusion

The most striking fact regarding all voluntary SSOPs is that few people choose to use them. The Medicare demonstration SSOPs are no exception: less than 2 percent of New York beneficiaries recommended for elective surgery obtained second opinions through the program, and less than 0.5 percent in Detroit used the program.

If a use rate of 2 percent of beneficiaries recommended for elective surgery and a reduction of 10 to 15 percent in the probability of surgery were achieved nationwide, then the maximum reduction in the total probability of surgery is on the order of 0.2 to 0.3 percent. This estimate does not take into account the indirect effects due to non-program second opinions resulting from program publicity (advertising effect) or a decrease in initial surgical recommendations resulting from the program's existence (sentinel effect). It seems unlikely that a significant sentinel effect would exist, since use of these programs is extremely low. However, it is not clear whether an advertising effect exists (Gallup Organization, Inc., 1980).⁶

⁶Supportive of an assumption that persons value and may be seeking non-program second opinions is a national survey conducted in 1980 by the Gallup Organization for the American College of Surgeons. This poll found that 25 percent of 1,571 respondents knew at least one person who had an operation that turned out to be "unnecessary." This survey also found that one in three respondents believe that most or some surgeons frequently perform operations that are not necessary. Moreover, in most cases (71 percent) the public feels that surgeons do so primarily for monetary reasons. In only 5 percent of the cases does the public attribute unnecessary surgery to honest mistakes. When asked what could be done to reduce the number of unnecessary operations that are performed, 49 percent spontaneously mentioned obtaining a second opinion.

The findings presented in this report indicate that waiving cost-sharing as an incentive for Medicare beneficiaries to voluntarily obtain second opinions does not appear to be sufficient encouragement for extensive use of the benefit. The voluntary SSOP's long-term goal is to improve patient decision-making. Voluntary second opinion program users are a select

group of beneficiaries actively seeking health care information. These beneficiaries decided that unquestioned compliance with surgical recommendations may not be in their best interest. For these beneficiaries, the value of the second opinion outweighed the varied non-monetary costs they may have incurred in obtaining it.

TABLE 2

Surgery Status for Program Participants One Year After Program Contact, by Program and Second Opinion Outcome

Surgery Status	New York			Michigan		
	Confirm	Non-Confirm	Total	Confirm	Non-Confirm	Total
Yes	63.1%	20.4%	49.5%	61.0%	22.2%	46.4%
No	36.9%	79.6%	50.5%	39.0%	77.8%	53.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sample Size	1,584	736	2,320	105	63	168

Source: Poggio *et al.*, 1981.

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